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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAM SERVICE

REVIEW COMMITTEE

Rockville, Maryland

Thursday, 13 January 1972

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES & MENTAL HEALTH ADMINISTRATION

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Conference Room G-H
Parklawn Building
5600 Fishers Lane
Rockville, Maryland

Thursday, 18 January 1973

Conference on the above-entitled matter was reconvened at 8:30 a.m., DR. ALEXANDER SCHMIDT, University of Illinois, College of Medicine, Chicago, Illinois, presiding Chairman.

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P R O C E E D I N G S

DR. SCHMIDT: If we can take our seats, I think we should begin.

Dr. Hess and Dr. Kralewski are probably still in the cab. There are a couple of little housekeeping details we can take care of before we get on into our agenda. Let's see. Where is Mr. Toomey? Is he here?

VOICE: He was here earlier.

VOICE: Lot of people were on the stairs up and down.

DR. SCHMIDT: We thought the order of the morning would be Intermountain, Maryland, New York Metro, Tennessee Mid-South and Arizona, putting Intermountain first. It's the one that has some visuals.

I remind you of the rating sheets that we should be filling out, the big sheets. And, lastly, it's been brought to the attention of staff that some of the Review Committee members really don't want their book sent to them, this book. So, we'll ask that those of you who do want the book, the Review Committee book sent to you, to leave a piece of paper on top with your name and say, "Send book," and those who don't want it, put a piece of paper out and say, "Don't send it." Because we discovered that at least one Review Committee member would get it and throw it away and it's a lot of work for the postmen and the staff to pack it up and so on if it

isn't being used.

So we will begin with Intermountain in a moment.

You know that the Surgeon General has determined that gum chewing is detrimental to health. It gives you cancer of the teeth.

(Laughter.)

DR. THURMAN: I might point out that's a defense mechanism as you light your cigarette.

(Laughter.)

MR. TOOMEY: The first thing, we have flip charts and I have several transparencies.

The Intermountain RMP encompasses, as far as population is concerned, a total of 1,850,000 people. It overlaps with two other RMPs: Colorado, Wyoming, and Mountain States.

The population of Utah is 80 percent urban, 20 percent rural. The four Mountain States, 59 and 41.

The American Indian population is only one percent in Utah and two percent in the Mountain States and the numbers, the percentage of blacks in the area is very small.

I think the next slide is a --

VOICE: Could we have the lights, please.

MR. TOOMEY: This slide is designed to show the original IRMP area which extended all the way across Nevada, pass Reno and into Montana, Idaho, Wyoming, Colorado, as well

as Utah.

The CHP agencies are not just the dots but they are the dots with the lines around them. There is a CHP agency here, here and here. There are developing CHP agencies in other places but there are none other than over into the Colorado area.

Now, very interestingly, the Intermountain RMP had its own turf problem because of its overlap with the Colorado, Wyoming RMPs and the Mountain States RMP.

The turf problem, in fact, was resolved geographicall by redefining the area and this now represents the area covered by Intermountain RMP which really carved a good bit of the Nevada and Idaho section out of the Intermountain RMP and some of the Colorado.

But I think the administrative decisions are the ones that are interesting because the three coordinators met together, they discussed their problems, the problems of the overlap, the problems that had arisen in terms of programs that had been established in the area and who should sponsor the programs.

They decided that they would create an organization which would be made up of the three coordinators, three staff members from each of their RMP agencies and three board members or three RAG members.

The RAG members would meet only when the meeting

was in the -- Well, let me back up and say, they agreed to meet in every other month and in the area of each of the RMPs.

So one meeting would be in the Colorado, Wyoming RMP and the other one in the Intermountain, and another one in the Mountain States and they would be in sequence every two months.

When they met, the RAG member from that particular RMP area would attend the meeting.

In addition to creating this organization -- and incidentally, the votes, the only voting members were the three coordinators -- but in addition to the organization that they developed themselves, made up basically of seven people who would meet to resolve whatever problems had arisen, each of the coordinators was a member of the RAG, ex officio member of the RAG of the other two areas.

At the time they met, if there were problems that arose that they didn't think they could realistically resolve themselves, or if the vote was a two-to-one vote -- in other words, unless it was unanimous -- and if the others wanted to appeal, the person wanted to appeal, there was an appeal mechanism established.

And I think what I'm saying is there was a turf problem. There apparently was some jealousy, some difficulties and they created -- in the resolution of this problem, they

first of all created an organization themselves which would handle the problem of including an appeal mechanism and, secondly, they changed the boundaries of the area.

So I think their resolution of their turf problem -- I've only been involved in one other -- but this seems to be a very suitable resolution and it seems to be working.

There's no doubt that one of the key elements in the development of these Regional Medical Programs has to be in the area of the goals that are established, the objectives that are established and the priorities and the activities that are established in order to carry these out.

Now, these are some of the things that I'm taking advantage of; the fact that using this mechanism to respond to some of the things that I have as part of my own presentation, but I would tell you that one of the main difficulties that I've seen with the IRMP has been the fact that they have defined four goals and there are no other really adequate objectives or priorities that have been established.

Now, the goals they've established, of course they do conform as goals to the major thrust of the RMPS: To improve accessibily, easing and simplifying entry into the health care system for all consumers; to increase availabilit by providing needed services in urban and rural areas with emphasis on minorities and other underserved persons; to improve the quality, assuring that the most appropriate medical

services and related health care are furnished; and, finally, to increase the comprehensiveness, providing a full range of services for prevention of disease and injury, health maintenance and rehabilitation.

In the section entitled "Process" in our review criteria, there is a section that's entitled "Goals, Objectives and Priorities."

Their RAG does meet and they do go over the priorities for the programs that have been established. So they do establish them.

But to the best of my knowledge and I did attempt to probe in this area, they have not gone beyond spelling out these goals in terms of the further refinements and developments of their program.

VOICE: Could we have the lights, please.

MR. TOOMEY: While I am here, I might as well just take up the funding situation. Their 06 year funding, their award was for 13 months which came to 2,915,000. When you annualize it or put it in the framework of the twelve months, their award for their sixth year was 2,690,000, and then they had a plus of the emergency medical services funding.

Their 07 year request is for 3,896,000 which is approximately a million two above their 06 year's funding.

DR. THURMAN: Bob, are you going to speak to their increase in staff later?

MR. TOOMEY: Yes, sir. I'm looking for the asterisk. Can you see it?

MRS. SILSBEE: Here.

MR. TOOMEY: Right. Their operational projects, two and a half million dollars including one million one seventy-two for the continuation of their 14 on-going projects and a million three for new projects.

However, we will come back to this, so I'll leave this slide up for this so you can see it.

Mr. Chairman, in 1972, the Intermountain RMP -- Is this working? Can you hear me? Okay. -- Intermountain RMP had been visited on April 17 for an orientation program and a RAG meeting, and July 12th to 15 for technical consultation and another RAG meeting. On July 20, to meet with the Mountain States, the Colorado, Wyoming and the Intermountain RMP as regards the turf problem, the boundary problems. Been visited in August -- that was April, twice in July, August 25 and 31, for a review verification, management, assessment visit. October, for a kidney consultation, technical consultation as regards the kidneys. October 12th, later in October, another technical consultation and a RAG meeting. November 9 for a RAG staff retreat and November 19 -- No, and again in November -- No, I'm sorry. November 9 to 10, I think, was the RAG meeting, the last meeting.

Because these meetings were I think relatively

important and they certainly, as I have read the material, were productive, it became rather obvious the areas in which problems existed in the Intermountain RMP.

There was a concern as to the program direction. That is, the extent to which it was moving away from the categorical program and into areas which were in conformance with the Regional Medical Program. And, frankly, over this period of time, it was obvious the project would develop and it was moving into these new areas.

For instance, they were developing relations with the CHP B Agencies in Pocatello, Idaho, Billings, Montana as well as within Salt Lake City itself.

They stimulated grant applications. They were involved in the stimulation of grant applications for HMOs, family health centers and proposals for migrant health work, migrant health care for the migrant workers; developing the health information testing center, program on diabetes, quality assurance, emergency nurse training and areas of consumer education.

So that I think in terms of the concern that was expressed over the period of the entire year as regards the major thrust and the movement away from the categorical concerns, that this was very evident that they were working in the proper direction.

The second concern that was expressed by the

visitors had to do with the existence of clearly defined goals, objectives and priorities, and I mentioned that as I spoke and showed you on the screen the goals.

I don't believe that either the refinement of the objectives nor the development of priorities is at the point in which we can say they literally have achieved their needs.

Another aspect of the development of goals and development of objectives and priorities, has to do with the fact that their concerns are widespread geographically, embracing different areas and different sections of the three states and as well as not having a very homogenous culture to work with, they have the geography and they have the different states and they have the different concerns in the different states, so that the refinement of their goals into areas or into into objectives and priorities can't be done on a single and a unitary basis.

I think they have to be concerned about the needs that exist in the periphery and outside the state of Utah. And what I'm saying is that there are different needs at different places and there are different priorities in different areas of the section they serve and that this has to be decentralized rather than centralized.

The third area of great concern was the grantee-RMP relationship problem. And the problem simply is this and it's

real simple: that the present coordinator does not have a desirable relationship with the president of the University of Utah and his assistant, Dr. Emery and Dr. King.

Second, the spelling out of the responsibilities of the Regional Advisory Group and the grantee in which there was responsibility for the activities of the RMP assigned to the grantee -- but there was authority to get the work done assigned to the RAG -- created a problem in the eyes of the people at the University of Utah because they did not feel that they should split the authority and the responsibility. And the University wanted, in fact, to be totally and completely responsible and to have the authority for running the Intermountain RMP.

They could not see giving up any authority to the Regional Advisory Group, and of course, the authority of the Regional Advisory Group is spelled out in a Memorandum of Policy of the RMPS.

Now, this situation has not been resolved. The University of Utah has indicated that rather than giving as much authority as our policy indicates that the RAG should have, the University of Utah said that they would give up the grantee position.

And I believe, to the best of my knowledge, that this is still weighing and that there has been no decision reached as to whether the university will, in fact, continue

as the grantee or whether a nonprofit organization will take place.

DR. SCHMIDT: Could I ask a question at this point. What is John Dixon saying? Because some of the participants in that dispute are leaving. Tom King is going to Columbia as Professor of Surgery. Fred Emery is stepping down as president. John Dixon is obviously a stayer, so what does John say about that?

MR. TOOMEY: Well, John had more to say about the relationships that existed between the Dean's office and the President's office and Mr. Haglund than he did about the situation as regards the two organizations.

Most of our conversation had to do with the personality problem as Dr. Dixon was there. I don't believe, I don't remember that he had anything to say about the grantee relationship.

DR. MARGULIES: I've had a letter from the Dean in which he described to me, about as well as I've heard it expressed, what the relationship ought to be, very strongly in support of our understanding of the role of the Regional Advisory Group. So that I don't think there's any real question about him accepting our policy and, in fact, believing it.

The difficulty is pretty well centered within the university administration and, particularly, the two individuals

both of whom are leaving by July 1 at latest.

MR. TOOMEY: I think it will be resolved. I think that's, well, kind of an obvious statement.

Dr. Dixon seems to be such a reasonable person and he seemed to have an understanding of the problems that did exist between the university and the IRMP, that I think with the departure of the two that you mentioned, Dr. King and Dr. Emery, that many of the problems will be resolved.

The personal problem of the selection of a coordinator, I think that I -- I might as well mention that now.

Dr. Satovick was the coordinator. He resigned and became a part-time coordinator from March to August of '72. In August of '72, he left and Mr. Richard Haglund became the coordinator.

Mr. Haglund's relationship with the university were not kind. They were not good, and it has created a kind of a continuing problem and it gets involved with the relationship between the university and the IRMP in that the president, Dr. Emery and Dr. King, felt that before they left office, that they wanted to be able to be in a position to select the next coordinator, and they did not want to select Mr. Haglund, apparently.

And, really, it's a further dimension of what is both an organizational problem and a personal problem.

In terms of replacing Mr. Haglund, the university,

or the RAG, established a Search Committee, and the Search Committee had several names suggested to it. They interviewed several people and they did not interview Mr. Haglund at the time.

At this point, they could not come to a decision as to whom should be selected as the coordinator and, consequently, they moved back and said, "If we're having these difficulties, then we'd better do something different than just interviewing people."

So they made an effort to develop a kind of a profile, if you will, of the person that they wanted. They spent a lot of time working on the profile and the criteria.

And when we were there in December, they had not initiated any further interviews. Frankly, both myself and I think for the site visitors, we didn't know whether or not the RAG was attempting to stall until Dr. Emery and Dr. King had left their positions at the University of Utah, or whether they seriously were just having difficulties in developing the criteria and looking for the people that were wanted, that they would like to have as the coordinator, or whether it was a little bit of both and a concern with possibilities of keeping Mr. Haglund on as the coordinator.

Because if the issue had come prior to Dr. Emery and Dr. King leaving and Mr. Haglund had been the selection of the RAG, I think we would have had a rather -- it would have

precipitated kind of another major problem, and it was my feeling that they were going to wait.

Now, I understand from Mary Murphy that they have begun to interview people and they may attempt to make the decision before too long.

I covered the turf problem and the tri-coordinator's agreement and the acceptance of this.

IRMP, because of its vast geographic area, the several states that it has to cover, has a problem in developing its subregionalization, its extension into the other areas, and the Regional Advisory Group and the coordinator realize that the full success of the program is dependent upon providing services and being concerned about the needs of all of the region and not just Salt Lake City.

They have taken action. They're working with CHP and health service educational activity centers and other areas, and I think they recognize that the area is too large to be operated centrally and the site visitors encouraged the IRMP to open regional offices in the other major areas of the region and to be staffed on a full-time basis.

There has been a concern early, early on about the effectiveness of the Regional Advisory Group and its method of operation. At the present time, the RAG does represent, both geographically and in terms of minority interest, consumers and providers. It has I think a very good mix.

Fourteen percent of the Regional Advisory Group represents minorities.

Their attendance is really great. Seventy-five percent of the Regional Advisory Group members attend all the four or five meetings per year that are held. They take a more active role in the total program. In terms of the participation in all of the activities, they are part of the Program Development Committee. They sit on the Technical Review Groups, and I would say that it's a very active role that they play now.

Their Executive Committee meets regularly. As a matter of fact, the RAG members chair the Technical Review Committees. The Technical Review Committees are health manpower, consumer education, health care systems, provider education and the RAG members are chairmen of each of these.

RAG members are involved in both program development and in the evaluation and review.

One other word about the extension of services to the periphery and the generation of ideas from the periphery back into the IRMP, there is no systematic assessment of the needs of the region. Apparently, planning has not been done effectively to get to the needs of the area.

I think one of the pluses, if you will, as I saw it, was with the change from Dr. Satovick to Mr. Haglund with the numbers of studies that were made and to be ready for the

site visitors, I was impressed by the way that Mr. Haglund handled this situation.

He had his organization ready when the surveys and the audits and the site visits were done. He did take action to restructure the organization to meet the need that had been spelled or had been indicated by the various visits.

He had worked in the development of the relationships with other organizations. The staff had worked toward the development of new projects. They were concerned when we were there with the development of a decentralized structure to better serve the areas outside of Salt Lake, and they expressed a concern for services to the periphery.

They had pretty well minimized the turf problem and I would say their relationships, other than at the top level with the medical school, were quite good, their working relationships below the level of the President and the Dean at that time.

For the program that they offer, they have 55 budgeted positions; 51 were filled. There were either three or four that were unfilled at the time.

Their projects that they had sponsored and which were supported by IRMP funds called for 114 positions. Actually that would be 82 full-time equivalents. And, Bill, I'm really -- except for the --

Their request for funding was 3,896,692 in their

seventh year; 4,125,000 in the eight and nine year.

The recommendation from the site visitors was that triennial was recommended with a funding level of $3,000,000 for each operational year, 07, 08and 09 and this amount would include a developmental component.

We felt the funding for the 08 year should be contingent upon the appointment of a full-time coordinator and the resolution of the RMP grantee relationship policy problem.

DR. SCHMIDT: Yes, I'll accept that as a motion. Mrs. Flood.

MRS. FLOOD: I had been assigned to attend this last site visit but was unable to because of a family emergency, so my review is strictly from the material.

I have some expression of concern that of the 24 projects requested for the coming year, ten of which are new projects and 14 are continuation projects, 18 are still based in the University of Utah with only six projects based out of the university setting. This presents some sort of problem for me to believe that the university and its leadership in RMP is really looking at the regionalization of the program.

I realize we're not supposed to look at specifics, but I do have one question to address possibly to Mrs. Murphy.

They listed in the current funding period that they're in now a termination of the emergency medical program,

Project Number 40; yet not for the coming year but for the following year, Year 08, they again request additional funds for the same project.

The current award in that project which was 174,000 then, they come back in year 08 and ask for 184,000 more with no funding in the immediate next year or Year 07.

Can you offer me any explanation on that?

MRS. SILSBEE: Excuse me. That's a fluke in the printout. That money was dropped in at the end of the fiscal year, this last fiscal year. The 225,000 or something is carried over. The period of time is too short, and under the ground rules, that was something like an 18-month award. So that accounts for that hiatus

MRS. FLOOD: Okay. Thank you for the explanation and the clarification there.

And the other concern is that the new projects being instituted do not seem to reflect a real look at their goals and objectives. And other than that, I guess I really don't have a great deal to offer of additional comments to Mr. Toomey's presentation.

DR. SCHMIDT: Would you be willing to second the motion that we have?

MRS. FLOOD: Yes, I would.

DR. SCHMIDT: All right. So at least for purposes of discussion then. Okay. We'll have to be getting a little

feedback. We'll have to cut down on one of them there.

All right. Well, thank you. Then the floor is open for discussion. Bill, do you want to follow anything up?

DR. LUGINBUHL: In view of the uncertainties about this program, the fact that there's not a permanent coordinator and that there is a fragile relationship with the grantee which may or may not be changed, did you consider making this award a one-year award and getting some of these matters worked out?

I'm struck that there are some fairly serious problems here, at least potential problems.

I'm also concerned that the level of funding as already awarded is really very high when you consider the population. I think it works out something like two dollars per head in that Intermountain area. I think yesterday we gave twenty-seven cents to Louisiana. That is a rather horrendous differential considering that there are serious problems apparently, or at least potential problems in this region.

MR. TOOMEY: I think there was a positive feeling after we got through talking with Dr. Dixon about the resolution of the coordinator problem and the relationship of the coordinator with the medical school. And to answer you, we did not seriously consider reducing it from the triennium

status.

DR. SCHMIDT: You covered that in a way by making 08 an 09 contingent on the appointment of a coordinator. The program does have a lot of people and it's a solid program and this is it's, what, second triennium that it's starting and it was one of the programs that got off to a quick start and was one of the first few made operational and it's always kind of been ahead of the pack, at least in terms of numbers of projects and money and so on, and the Review Committee has had many discussions about what has been termed in the past the cost of emptiness or the cost of mountains and distance and that sort of thing which has been one of the factors in formulae that people have proposed.

MR. TOOMEY: I'd also told Dr. Luginbuhl that, you know, he's absolutely correct in what he says about Louisiana. But I think if you remember, we agreed that the problem was not at this level in terms of granting funds to Louisiana, but it was at the Louisiana level in terms of developing a program which would provide more funds to them.

I don't think that they were reduced to that million dollars. I think that, on the contrary, they're encouraged to move ahead more rapidly with their programs so that they would be in a position to request more funds.

Now let me also say one other thing in terms of Mrs. Flood's review. I personally expressed concern about a

number of their projects. For instance, they have a hospital administrators educational project. It's my own opinion that that is the responsibility of the hospital administrators organizations that were and are involved in enhancing the capabilities of administrative people. And I don't know that it's the IRMPs responsibility.

There's another one that had to do with the matter of safety, electrical safety, electrical hazards in the hospital. I feel that this is an administrative responsibility for each of the institutions to be concerned about, the safety of their patients within their institution, and there is some justification in terms of economies and the safety and well-being of all of the people in the entire area to be sure that the institution is safe.

But I think this is a project. There's also a very, very major amount of money being allocated to the health information testing center and I think they say that the break even point is at 20,000 visits, and I think in the first few months -- I don't remember. Mrs. Flood, they had something like --

MRS. FLOOD: Seven hundred and fifty.

MR. TOOMEY: Seven hundred and fifty visits to the health information testing center.

DR. LUGINBUHL: Is that on multiphasic screening?

MRS. FLOOD: Multiphasic screening.

MR. TOOMEY: I might say I went through it earlier and I went through the health information testing center and I wanted to see if and Mrs. Murphy had suggested it would be desirable.

I was very much impressed with the program. But it's a question of whether, in terms of cost benefit, that will be the benefits coming to the area in any kind of a relationship to the cost of the project.

So that as you look at the individual projects, and I believe Dr. Scherlis was concerned about this yesterday, there are some I think that are questionable. There's absolutely no doubt in my mind that the reduction from their request to what we proposed is minimal. I mean I think that allowing for the increase from the two million six to $3,000,000 is more than satisfactory.

MRS. FLOOD: I would just like to reinforce Mr. Toomey's comments in the same line again. Along with the electrical hazards and the administration management training programs, they have an infectious disease control program in hospitals and they are not feasibility development demonstration projects.

These are actually three-year projects proposed for the maintenance of these services. The infectious disease control program is one of monitoring laboratory functions and culturing, and these are services that should be -- the

responsibility should be assumed by the institutions providing health care and I do not feel that they are a responsibility of this Regional Medical Program.

MR. TOOMEY: I think this goes back to looking not only at the development of the goals, but I think that it points up once again the need for them to get more concerned about what they have to do to achieve these goals and I think their projects have been developed out of context with the establishment of any objective.

DR. SCHMIDT: Dr. Thurman.

DR. THURMAN: I don't mean to dredge the values of Louisiana, but, Bob, you just said that Louisiana needed to develop a program that would bring more money in.

I'm not sure, with the exception of the 500,000, and I think that's a reasonable figure for their kidney in this year, I'm not sure that they developed a program that deserves support any more than Louisiana does.

There's already one point two million in the multiphasix screening and they're asking for almost 300,000 this year. And yet we know they're only running 750 patients.

Just on that basis alone, to go back to Bill Luginbuhl's comparison with Louisiana, with all this talented staff and all the time that they have, I don't see that they've got a program that they've identified that is that worthy of support versus the program that we saw at Louisiana. That

would be my concern.

Ed, did the technical consultant and kidney do reasonably well as far as these 53 ABCX projects are concerned?

DR. HINMAN: We don't think so --

DR. THURMAN: Thank you.

DR. HINMAN: --unfortunately. It's one of those technical reviews that was prior to our orientation --

DR. SCHMIDT: Do you want to grab a mike, please.

DR. HINMAN: We have some concern over the large kidney project that was submitted by the IRMP. This was a pulling together of nine components that have been in existence for some time into a comprehensive plan.

We have no hang up over the plan itself, but we're concerned about the method of funding, i.e., IRMP support. This was reviewed by technical reviewers prior to the time when we had an opportunity to have indoctrinated them into the concepts of decremental funding and that RMP money should be gotten out fairly quickly.

The problem is that, for instance, the home dialysis component has had six years of RMPS support from home dialysis training, a total of $1,222,000 in the past. It was known by that unit that it was to have been self-supporting by June 30th, 1972.

The home dialysis unit had also provided $44,000

towards the transplant startup and it had also, the transplant unit had, received support from an organs procurement contract for the past three years for a total of $194,796 and they knew they were supposed to be self-supporting by the end of three years.

Now, this nurse dialysis training program that they propose to make a national resource has been discussed with no one outside of Salt Lake City. The nurses that have been trained to date have all been from IRMP and there has been no evidence that we could find that would suggest that this indeed could become a national resource.

They had made no move other than to ask for money to do so. So that our concern is not with the coverage that they want to provide for patients, but the fact they have had three to six years support for most of the components and have not utilized third-party reimbursement that have made -- of course, the application came in before HR1, so they were unable to adjust to that.

But we have, and I think that it was put into the books, a funding recommendation for a total of, in the 07 year, $159,400 of RMPS funding as opposed to the five hundred and twenty-five that they requested; and the subsequent years, a similar reduction.

MR. TOOMEY: Fifty-four thousand the second year and eighteen thousand the third year.

DR. HINMAN: It's not that what they want to do is not good. It's just that it doesn't seem appropriate for us to pay for.

DR. MARGULIES: I wonder, could I interject at this point. I think that this discussion has become remarkably important, not just for IRMP, but the fact that you're going back and looking at Louisiana and wondering about some issues.

We agonize regularly in this program about the kind of disparities which you are addressing. On what basis, aside from historical accidents, is one justified two dollars per head one place and twenty-seven cents per head another?

Well, in the process of trying to find a resolution of course, we've looked at all kinds of factors like cost need and so on, but here you have a very good example of an issue around which some discussion can flow that might lead to some conclusions.

The argument in the case of Intermountain RMP is that covers a vast area. It has essentially one medical school available in contrast with, say, Louisiana which has three, and as a consequence, we are saying, at least implying if not saying previously so clearly, that under these circumstances, a greater investment is necessary to achieve the purpose which is improving the health care of the people in that area.

Now when you go beyond that issue, you are now doing

an examining to see in what way IRMP is responding to these peculiar needs of the Intermountain area and find activities clustered around the medical school concentrated around a series of activities whith tend to whirl around a university health science center and see in what way they are filling that vast space and those scattered areas with the funds that are available, you do raise some very serious questions about its fundings and its directions.

In its defense, on the other hand, as Mac has pointed out, it was not only an early program but one which was encouraged to move in the directions that it did elect. It was given great, great support in early days by review committee and council to establish a kind of direction which it has established.

And, yet, for a very long period of time, we have been pointing to places like Nevada and Utah and contiguous states like Colorado and wondering how effectively this money which is so much per head is being utilized to fill the empty spaces that they are trying to approach.

What Dr. Hinman has just described in the kidney program is, if at least not characteristic, one of the issues which is involved in your deliberations.

MR. TOOMEY: There's one other thing also, Dr. Margulies and Dr. Schmidt, that seems to bear out the discussion yesterday particularly by Dr. Scherlis as regards, on the one

hand, you look at the program, and when you look at the program, the RAG is changed, the staff is quite excellent. They have one major problem in the selection of an evaluation or in the area of planning and evaluation and the coordination of these activities. And there's no doubt in my mind, as I look at what came up in terms of problems as regards the program, actions and activities to rectify those problems, that this IRMP is really an excellent organization at this point with some problems.

On the other hand, when you look at the projects, the projects are a carry-over from the past. They are centralized at the university. They really do -- while they tend toward the goals that have been established, they are not in fact fully consonant with what you can almost perceive as the needs of the areas.

They are things that have been developed because of somebody's personal interest, and where I give the program probably a rating of an A in terms of what they did in order to overcome and offset their problems, I would barely give them a C in terms of the projects that have been established to carry this out.

DR. SCHMIDT: This is a very difficult thing. Sometimes I make a mistake in that I read everything that comes into my office pretty much, and one of the things I recently red from RMP that came to my office was an obvious

concern about the involvement of hospitals in RMP. And this was felt important enough whether it was political or not. It was felt important enough to do a staff survey on the involvement of hospitals in RMP. And there was some agonizing over the fact that hospitals are not as involved in RMPs as they should be.

And if you really look at how hospitals can be tied into RMPs, you do get into things like training programs for administrators, helping hospitals who would not have the sophistication in electronic engineering to pick up the subtle threats to life posed by equipment that nobody in the hospital understands.

These sorts of things, you can, in other words, if you put your mind to it, at least find some rationale for projects.

I agree with Dr. Margulies that this is an important discussion and I always have a growing sense of unease when the Louisianas are brought into a discussion like this.

The Oxford English Dictionary defines the word "mediocre" as average, and the big problem of a democracy, the greatest threat of any democracy is that, carried through, it inevitably leads to mediocrity.

If you bring up the Louisianas and start averaging, you're going to get down to a million dollars. You're going

to get down to some mean, to some average, and if there are 50 regions, that's a fifty million dollar program. If it's a two million dollar average, then it's a hundred million dollar program. And there is an element of ridiculousness to that.

Now, I'm not arguing for supporting a program becuase it's got a lot of money in it now. I'm arguing against backing off a good program.

I recently poured tremendous resources into one department because I know it was a minor department. I happened to recruit superb opthalmologists, and I poured resources into opthalmology, much to the dismay of some others, but that is some place where this particular school can make a difference because of the people that's there and so on. And I think that we're putting money into places where it will make a difference and I really do worry about the ultimate direction of the program and so on when we make too much of the money differences.

The review committee, by and large, through the years has strongly resisted capitation formulas and this sort of thing and, personally, I believe rightfully so, and I've obviously stimulated some comments.

Dr. Thurman.

DR. THURMAN: Well, one would not want to interfere with that beautiful monologue, but let me point out that if you

pour money down a rat hole, it doesn't improve it by pouring more money down it necessarily. And nobody here, so far, has said they have a good program, Mr. Chairman. That's the problem, and that's what we're speaking to.

I have no disagreement with the triennial status because this is a group of individuals who have proved their organizational capability but they have not proved their thought capability by this demonstration of projects that we are looking at this morning.

And I think that I'm not comparing per capita and I would agree one hundred percent with that part of what you said. That would be a mistake. What I'm looking at is the amount of money that they have now, what they're asking for, and how they would plan to use that money.

This has nothing to do with what Mr. Toomey said about their capabilities or with what you said about their overall approach. But I do say that for all that talent, sitting behind those desks, largely in Salt Lake City, that they have not demonstrated to us a program capacility that goes along with their overall capability, and that's all I'm saying.

And I would wash out the Louisiana and everything else quickly because I agree a hundred percent with what you said.

DR. SCHMIDT: Dr. Luginbuhl.

DR. LUGINBUHL: I certainly am not arguing in any sense for capitation. I agree that the program should be funded in a large measure based on their capability and performance.

I am hard pressed for looking over the documents, though, to arrive at the conclusion that this is a particularly capable program. I think in the past, they seem to have done pretty well at a time that the competition was rather different and the goals were rather different. But it looks to me as though they have not kept up with change, that they're still a program that is doing things that they started four and five years ago. It's largely based in Salt Lake City.

I think there are major problems about the leadership of the program when you have an acting director who's in conflict with the grantee that isn't resolved, and I don't agree that this program at this stage deserves a three-year green light. I think this program has major problems to solve. I think it needs to shift its direction.

I think that it should have its funding cut to a level and it should be looked at again in one year to see if indeed they haven't solved the problems they faced. I'd like to see some performance.

DR. SCHMIDT: Could you defint "shift its direction".

DR. LUGINBUHL: Well, as a start, I'd like to see them get more projects outside of Salt Lake, out elsewhere in

the region which they've been advised to do before. It looks to me as though the projects are still dealing with categorical problems, that they're not making a broad attack on the overall problems of health care delivery.

For example, a project in multiphasic screening, I don't really regard as an innovative project in health care delivery, in spending over a million dollars to screen 750 people. It's not a very cost effective program.

DR. MARGULIES: I think this is worth pursuing. I hope that Mac was not reflecting what he thought I was implying because I certainly have no interest whatsoever in a capitation approach.

What I am saying is that there should be a disparity based upon quality and perhaps some other factors but the disparity should produce some result, and if it is going to be more money in a region, there should be some evidence that for money, you're getting more results. It's that simple.

If you look at the size of this staff relative to other programs, it's a huge staff, and then take a look at the indirect costs for this particular program, I don't know if they're before you or not, but if they're not, you would have a reminder of it, you have to ask yourself, "If this the best way in which this money can be spent for the people who live in the Intermountain Regional Medical Program area?"

And if not, then you have to -- there comes a time when you begin to at least discuss this as a principle, whether you want to act on it now or not.

MISS ANDERSON: Mr. Chairman, I was wondering if the site visitors found our what happened to the projects that were discontinued. Did they have continued funding, or what --

MR. TOOMEY: I don't remember specifically, but their record of continuation of funding is pretty good.

DR. SCHMIDT: The site visit report, I think as I recall reading it over, said that out of 14 projects that were phased out, nine were picked up by other funding.

DR. THURMAN: Right.

MR. TOOMEY: I would say once again, that if you look at the component parts of the organization itself, the Regional Advisory Group has matured, and they are participating and I think certainly that, from what I've seen, you could rate them at an excellent level.

When you look at the staff, its organization, the kind of people they've got, that's rated as excellent.

The one weakness at the moment is the loss of a chief of their evaluation section and no replacement there on a permanent full-time basis, but a temporary person or a person who is full-time, but temporarily in charge of the evaluation section. This is good.

They do need one change in that and I think the management assessment people recommended that evaluation be involved at the very beginning and that they monitor the programs as they go through. The evaluation people at the beginning could establish the objectives that should be evaluated.

I don't want to go through it, but I think in terms of the program, once again, it's excellent.

In terms of the projects that are being carried on, I think they're less than excellent. Charlie Hilsenroth reminded me that this has been rated as a B-plus agency, and I think that you average out the excellence of the staff and the not quite so excellent projects at the moment and that's about where we would come, I would presume.

I think my own opinion is that really the development of the objectives and then development of projects to achieve these objectives is the direction that they have to take in order that their activities match their capabilities because they are an extremely capable organization as I see it.

DR. SCHMIDT: John.

DR. KRALEWSKI: A statement and then a couple of questions. First of all, it seems to me, in looking at this application versus some of the older ones, that they have made some change in their orientation and I think that they probably do have the capability to carry out that change as they go along.

Much of this will depend on the new coordinator, however, and I wonder if the site team has some comments about whether or not you think they're going to fill this spot fairly soon, were you impressed with the candidates they're looking at, what are their capabilities?

And then a second question, in terms of budgets here, it appears that much of the difference between the budgets they're requesting and last year's budget is involved in things such as grants, et cetera, and I'm not sure I fully understand that. It appears that last year, it didn't cost them anything for rent. This year it's going to cost them $138,000. These are differences that I can't quite see how they're put together.

MR. TOOMEY: Well, the rent issue, as far as the rental is concerned, they were using facilities provided by the university, and they were divided up into three or four different locations throughout the university setting.

They have felt that in order to pull the unit together, that they should find quarters where they all can be together and there is a research -- No. I want to say a research triangle -- but there's a research park. And they plan to rent quarters at that research park which is away from the university but does bring all of their staff together, and that's where the rental problem comes up.

DR. SCHMIDT: Dr. James and then Miss Kerr.

That will be the indirect cost.

just quickly --

: Oh, yes, on the coordinator business.

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Mr. Haglund.

Well, excuse me, she didn't say that, but the implications were that this was the action going to be taken.

DR. SCHMIDT: Dr. James.

DR. JAMES: I would like to approach this just from another point of view. Relative to the excellent way that the information regarding the total program has been disseminated throughout the IRMP in that there apparently has been knowledge gained by other agencies, consumers who have benefited from the program, I wonder whether or not can the site visit team tell me the impact of the total program as it has related to the provision of services to the people in this large geographical area?

I wonder, for instance, we get caught up here on all the technical gobbledegook regarding a new coordinator which can be taken care of at one level, but then the impact of the program in terms of just what are these projects doing, are they really reaching the people, are they servicing the people? And if not, if then that the budget considerations are as we see them here, which may look excessive as compared to Louisiana and/or Mississippi or wherever, would the budget considerations not be concerned with whether or not the 14 programs that are on-going, the new programs, are they reaching the people? Can the site visitors tell me this?

I don't understand the conversation up to this point. I think that I really want to know what's happening to

the programs in meeting the needs of the people in the communities in the area in the region.

MR. TOOMEY: I think I would answer that they have added things that were not available previously and to the extent that they have done this, they have met the needs of many of the people whose needs were not being met previously.

Now, it may not be all that you want, but it's a positive factor. For instance, they've worked very closely with the Comprehensive Health Planning Agencies. Now, this is a move in the direction. This is just not in Salt Lake but in helping in other areas, in developing Comprehensive Health Planning Agencies and working with them, cooperating with them and providing some funding to them.

This is in Pocatello, Billings, Montana, as well as in Provo. Their health learning centers in Pocatello, Idaho is providing additional manpower and, hopefully, additional services to the people.

They have moved out into the migrant worker area and they have moved into the Indian -- meeting some of the needs of the Indians.

So I would say, overall, the answer was yes, that we were satisfied that they were moving in that direction.

DR. JAMES: It apparently seems then, from the material that I have scanned, that this IRMP has indeed involved other health-related agencies and lent support to helpi

them develop programs which, in fact, does get down to the grassroots level of providing the services, is that not right?

MR. TOOMEY: That's true.

DR. JAMES: So what we're really discussing at this particular point then are probably the technical difficulties in administrative staffing or the administrative level. Does this not seem to be where we are at this point?

MR. TOOMEY: I would say the main problem --

DR. JAMES: And what are you using as a basis to evaluate this whole program and to justify the budget staff requirements or program requirements?

I would like a clarification on that, please.

DR. SCHMIDT: Well, I would try to summarize much of the discussion by saying that there have been an awful lot of activities in the Intermountain Regional Medical Program which have undeniably done well by the people and for the people and so on.

The major concern is that they have a set of goals. They have not broken these down into objectives and related them to the demonstrated needs in a satisfactory way.

The relationship of these projects to their objectives and relation to the people is less clear than one would like.

There's concern that the projects are in some instances very expensive and are not being phased out in a

decremental way satisfactorily.

Elizabeth.

MISS KERR: I think we've hit a key issue and I think --

DR. SCHMIDT: Do you want to grab a mike.

MISS KERR: Yes. I say I think we've hit a key issue here and I sense we've sort of taken 180-degree turn.

I would have difficulty in supporting Mr. Toomey's rationalization that this corps staff was extremely good, and the program, in essence this is what he said, was not very good. Yet they would average out at C-plus, and this is where I run into a very moralistic problem, as far as I'm concerned, in rating.

Now, if they have an excellent staff of 50 some people that are making the right decisions, then the program ought to be better. And this is why I get confused.

I thought you said the program was good. I agree that I kept hearing that the people needs were being met and that's what we're after.

MR. TOOMEY: Well, one of the problems here, in answer to Dr. Thurman's earlier question, is that I think there are kind of two kinds of staff in a way you're talking about.

One is what we would ordinarily consider the core staff, the leadership staff, and another great segment and then

probably the majority of the staff is project staff. So they tie together people in the project, and a lot of the additional 782, the 1066 monies would go to support people that are tied into these new projects that they're applying for. So that let's say that more than half of the staff is project related.

I think that the general consensus has been that what we would consider the core staff through the years, has been good. I think that's fair.

MISS KERR: Yes, but I still am concerned if they come up with a high rating because of this strong core staff -- and I'm not talking about this particular region alone -- but then sometimes we don't read it right, it seems to me, in their activities, in their performance and effectiveness.

DR. SCHMIDT: Joe.

DR. HESS: I think over the years, this has been considered to be one of the more effective RMPs. And I have no doubt that much of what they're doing is indeed affecting the health of the people.

But there's another consideration which hasn't been brought up here which I think we need to take a look at and that is the issue of the relative need of this region in relationship to other regions.

I don't believe that the RMP, using public funds as it is, should appear meritocracy (?).

In other words, the merit and the capability of the program should be the only factor. The need of the region should also be a modifying influence as best we can determine what those needs are.

And along with some of the questions that Dr. Luginbuhl was raising and some of the comparisons, I think we have to be concerned at this level about our consistency as we look at these various regions.

Now, Louisiana has been raised as one example, and I would point out for our consideration what our deliberations were concerning Washington and Alaska yesterday.

You look at the quality of that program as it was described for us. Their funding level for a population of 3.7 million people, we recommended $2.3 million which comes out to about sixty-two cents per capita. You look at the health indices, the ones that we have in the report, in every respect, considering heart, cancer, stroke and all other causes of mortality rates and considering that as the only numerical data that we have for comparisons, that the Intermountain region is better off in all of those categories, significantly, than the Washington-Alaska region.

So there are other factors that are not as quantifiable that we have to take into consideration. But the point I'm trying to get to is this: that as we try to make recommendations about the various regions, that we ought to consider the needs,

the health needs of the region as well as the capability of the staff and the recognition that if we overfund some regions, that is automatically going to have some repercussions on others in terms of their getting money.

So, consequently, I believe that this region, even though it's had a good program and all those things, its geographical problems, it's overfunded at the current and at the present time and that we ought to start a trend to cut this region back to what is more equitable in terms of where they stand in the national picture.

DR. SCHMIDT: All right. I'll use that to --

DR. HESS: If you're ready, I'm prepared to make a recommendation.

DR. SCHMIDT: All right. We have a motion that's seconded on the floor for level funding for the second triennium of $3 million, with two contingencies: one that by the second year of the triennium, i.e., they get $3 million for the next year, they would get $3 million for the 08 year providing a permanent coordinator was chosen and they settled the issue with the grantee organization.

If you wish to make a substitute motion, that would be in order.

DR. HESS: Yes. I would like to propose that in place of the $3 million for this next year, we recommend 2.5 which is below their current year funding and that for the

year after that, that it be 2.3 with an indication that we think that this trend ought to be reversed and there ought to be a levelling off at a lower level. And then it's up to the ingenuity of this staff to make the best use of the funds which they have to meet the health needs of the people in this region.

DR. SCHMIDT: All right. If you're talking about a triennium --

DR. BRINDLEY: Third year.

DR. SCHMIDT: -- what sorts of things would be falling in year three?

DR. HESS: Well, I would say if the third year were also at 2.3, taking into account inflation as long as there would still be a relative cutback in the third year.

DR. LUGINBÜHL: Second.

DR. SCHMIDT: All right. There is a substitute motion then. It is seconded. It would be 2.5, 2.3, 2.3.

Dr. Luginbuhl.

DR. LUGINBUHL: I just want to point out some interesting features in the budget in the 07 year. If I read correctly, there's included $300,000 for developmental components $300,000 for multiphasic screening, probably half a million dollars going into the renal program, and these are all items that I would question. And if you look at the projects, the new projects and you split out the renal project, the ones

that appear to be the most innovative are all subcontracts, and the projects that are being continued are rather categorical.

And I wonder what the staff is going to do if the categorical projects are phased out since the new projects are subcontracts?

It seems to me if you cut this program back, that there is plenty of room for some readjustment and redirection and the only thing that I still question is whether this program should be given a three-year green light or whether it should be looked at in a year to make sure that they are indeed following a new direction.

MR. TOOMEY: I have to speak against Dr. Hess's recommendation, not in principle truly, but in terms of the dollars.

I think that you could cut back perhaps the first year. But they are assuming some additional direct costs, for instance, in their moves to bring together their staff from several places into one place which, I think, will make a difference in the number of people that they have.

Having a decentralized operation is more expensive in terms of people and having them all together.

Consequently, if Dr. Hess would give consideration to perhaps the 2.5 and then increasing it for the next two years, I think I could support this. But I'd have to speak against what he has proposed at this point.

DR. SCHMIDT: All right. Let me ask staff, do you have any comments? You've been silent. Do you have any comments as to what in effect is a reduced funding level?

MRS. MURPHY: I could see the 2.5 and we do need an earmark in the kidney.

MR. TOOMEY: But that's within the 2.5, so that really is no problem.

DR. SCHMIDT: Yes. John.

DR. KRALEWSKI: I'd like to make a comment about the principle of this, unless I misunderstand what we're doing here. I really think that we're voting on this or trying to develop their budget on the basis that we really feel they're getting too much money for this region or some kind of an approach such as that and I'm really opposed to that.

I really think that we've got to continue on the basis of looking at programs, looking at their capabilities to do things, whether or not they've made a contribution, and then deal with the budget in those terms.

Now, if we think that they haven't made a contribution and they don't have the organization to be able to make a contribution, fine, let's cut them back.

But going on this basis that they've got three million and someone else has one million and we need to, therefore, bring them into a closer balance, I think is a bad

way to go and I would be opposed to cutting them below last year's funding, at least, because I think that they got some things going here. I think they've indicated some changes.

I think they're making a contribution, both to the rural areas and other areas, and I think that at a time when they need some help in their attempt to get away from that medical school, which appears they're trying to do and attempt to bring in a coordinator, which they're apparently close to doing, and if we cut them back, I think that it's going to put this guy to a real disadvantage.

DR. SCHMIDT: There is one other issue that bothers me a little. I'm bothered by the substitute motion a little bit. A part of it, a number of people have talked about the need to get out of the categorical business.

I would point out to the Committee that that is in conflict with some of the statements that have come out of the HSMHA office and the RMP central office recently, and I think there is need for a little clarification of this.

Harold.

DR. MARGULIES: Well, I think that the issue on categorical activities is more a matter of how they're carried out and whether or not heart disease is an important disease to take care of. I think there can't be any question about that.

What we're trying to avoid, however, in moving away

from categorical, categorical activities is the support of separate projects which are identified around a single aspect of a single disease located in a single institution which tends to split a delivery system even further rather than strengthening it.

I think a good example of how to improve cardiovascular disease management would be one which involves a strengthening of the total management, we'll say, of congestive heart failure or hypertension to better management of an existing delivery system, and a bad example is the enthusiastic development of a coronary care unit in a 45-bed hospital. I don't know if they're down to 45, but we have some in similar circumstances.

It is more of a matter of how you get there.

There's no question that one cannot have an effective health delivery system mounted without careful attention to the diseases with cause major disability and death. But there is a sensible way to go about it, a rational way, and there's a kind of impulsive, fashionable pattern which characterized the program in the past.

It isn't dealing with categories that disturbs us. It's dealing with aspects of diseases which concentrates resources in limited areas at the expense of other needs. So that when we use the word "categorical," it gets us into a little difficulty.

If the program has designed, as an example, a regionwide method for dealing with coronary artery disease so that the total management for all available people is improved at every level and is not simply restricted to training a few individuals to do a few things, then I think it's going in quite the correct direction.

I am a little worried, also, Mac, about using the word "categorical" as though it was a bad thing. It's not bad. It's a good thing if it's done the right way and I think troublesome if it's done wrong.

MR. TOOMEY: I wonder is I couldn't appeal to Dr. Hell to change his motion to allow for 2.5, 2.7 and 2.9 over a period of three years.

DR. SCHMIDT: I'll rule that out of order. That's tampering with a motion and I won't allow pressure to be put on motion movers.

We have a substitute motion if you would like to move a modification, a substitute motion, that is --

MR. TOOMEY: I would so move.

DR. SCHMIDT: All right. Make a motion.

MR. TOOMEY: I would move that the amendment be modified to change the amounts specified to two and a half million the first year, t.7 the second year, 2.9 the third year.

DR. SCHMIDT: All right. We have a substitute

motion on the floor that is now a motion to amend, two five, two seven and two nine.

MR. TOOMEY: May I add to that motion then, also with this, that advice be sent to the IRMP not only as regards the resolution of their problems with the university and the resolution of the selection of a coordinator, but that attention specifically be paid to establishment of objectives which would support their goals and that the project selection be given particular attention and that concern be directed to the needs of the periphery.

DR. SCHMIDT: All right. I'll accept this. On the Executive Committee, unfortunately, I have a lawyer and he would point out that your amendment is really a substitute for the substitute motion and I'm stretching it a little to accept that as an amendment, but we did it yesterday, and so I'll be consistent.

DR. THURMAN: That's right. Consistent in being wrong.

DR. SCHMIDT: Now, so we're speaking to the amendment to the substitute motion which is two five, two seven and two nine. Dr. Luginbuhl.

DR. LUGINBUHL: Well, it strikes me that we're beginning to close in on some agreement.

The one issue that I have raised, and I really haven't heard discussed, is the question of a site visit at the

end of the year and just in the interest of moving things along, is that a dead issue or is there any sentiment? Could we see if there's any sentiment in the group? And if there's not, I think we can drop it and proceed to settling the financial question.

DR. SCHMIDT: All right. Anyone who feels that the program really should be site visited within a year, raise your hand.

(Show of hands.)

DR. SCHMIDT: All right then. The majority feels that probably they need good, strong advice saying that we'll be out in a year to look at this and so on.

All right. Let's keep now to the motion on the floor. Are you ready for the question?

DR. BRINDLEY: Question.

DR. SCHMIDT: All right then. We're voting on the amendment to the substitute motion. All in favor, say aye.

(Chorus of ayes.)

DR. SCHMIDT: Opposed, no.

VOICE: No.

DR. SCHMIDT: The amendment carries.

(Motion carried.)

DR. SCHMIDT: We'll vote on the substitute motion then which is really kind of silly. All in favor, say aye.

(Chorus of ayes.)

DR. SCHMIDT: Do you understand that we're --

VOICES: No.

DR. SCHMIDT: The motion was amended. Now, we have to carry the main motion which we really just voted on, which is two five, two seven and two nine.

VOICE: So you have to vote negative then.

DR. SCHMIDT: It's the same thing as yesterday.

DR. LUGINBUHL: We voted to amend the motion and now we're voting to pass the amended motion.

DR. SCHMIDT: That's correct.

DR. THURMAN: Question.

DR. SCHMIDT: All in favor, please say aye.

(Chorus of ayes.)

DR. SCHMIDT: Opposed, no.

(Motion carried.)

DR. SCHMIDT: All right. I believe that finishes us then with Intermountain. Mr. Toomey.

MR. TOOMEY: May I suggest, also, because the kidney funds in this project require earmarking, I think they also require a separate motion; that is, that the sum of --

DR. SCHMIDT: The kidney dollars are included in that figure.

MR. TOOMEY: They are included, yes. They need an earmarking. Can we do -- Do you want a motion on the earmarking or is it necessary?

DR. SCHMIDT: I don't believe it's necessary.

MR. TOOMEY: All right. They are earmarked.

DR. LUGINBUHL: Where do we stand on the record for a site visit?

DR. SCHMIDT: We stand at: the review committee is recommending a site visit in one year.

All right. Thank you.

I really feel that the discussion was very, very good and important. We'll move on then to Maryland, and Dr. Ancrum.

Well, do you want a break before we go in to Maryland? Maybe we should. We'll take a fifteen-minute break. Now I'm going to have to tighten up on time. Ten thirty, we'll start.

(Recess.)

DR. SCHMIDT: Okay. If we take our seats, we'll begin.

The Governor of the State of Maryland gave a state of the state message yesterday, so we've heard about that. We will hear about the State of Maryland RMP. Dr. Ancrum.

DR. ANCRUM: Well, just for a little bit of the background on the Maryland RMP. It covers the State of Maryland with the exception of Montgomery and Prince George County. However, it includes York County in Pennsylvania.

It has a population of slightly over 3,000,000 with

70 percent of the state urban and 81 percent caucasian residents.

Baltimore is the major city of the state and it has a little bit over 100,000 population. All the other cities in the state have less than 100,000.

For the health statistics, their mortality rates in heart disease, cancer and stroke is lower than the national average as well as deaths from all causes.

In health manpower and facilities, they do have two major medical schools: Johns Hopkins and the University of Maryland, both located in Baltimore.

They have 25 schools of nursing awarding the RN diploma, 20 schools of nursing for LPNs, four schools of medical technology, two in cytotechnology, 16 in radiologic technology and one in physical therapy.

For health manpower, they have 5,725 M.D.s, approximately 10,000 RNs with about 50 percent of them being inactive. Although there were 900 LPNs with about one-third being inactive, they do have a complete range of health care facilities including acute, long-term and extended care facilities.

And I talking to the mike?

VOICE: You're all right.

DR. ANCRUM: For a historical profile of the region, the Maryland RMP was awarded an initial planning grant in January of 1967 and was approved for operation in March of

1969.

This is a region that has had many concerns both to the national council, the RMP staff and the reviewers since about 1968. The major concerns have been their lack of moving toward regionalization and also a lack of coordination of the various projects of the program. And there's also been concern about the program being co-opted by the medical school.

Upon receiving the second year continuation application, due to the many concerns that were raised, there was a site visit made in May of 1970. And this is the same concern existing from 1968 until '70, these being primarily the ones that I mentioned: the absence of satisfactory outreach to the extent that the program was known as the Baltimore program.

There was an an absence of cohesiveness between the project, program staff units, projects and programs, and there was no visible evaluation of the various programs.

Also, their application was primarily futuristic in tense, and the RAG was predominantly a Baltimore based and controlled RAG group.

A second site visit was made in December of '71 and, at that time, I was also one of the site team members. At that time, there was still most of the concern that had been expressed early still present; namely, that it was a

predominantly Baltimore based activities for the programs in the community and, also, for the medical school.

There was an absence of a data base to substantiate the new program directions. At that time, the application did contain goals and objectives based primarily on the new mission policy that had come out, but there was no way to determine how they went about establishing these goals or objectives or what base they had used to determine at least what they needed to do.

There was still a lack of activities being extended to the other regions other than Baltimore.

Also, the epidemiology and statistics center was providing very little information to help them in making decisions. The RAG group still was not functioning as the primary -- providing very much leadership in the program problematic decisions or pointing out overall goal and strategy.

These were the major things I came up with during the 1971 site visit.

Since then, in September of this year, the 25th, they did have a review verification visit and also on the 26th and the 28th, a management survey visit.

In summary, the verification was approved at a minimum standard and there were several recommendations made, primarily the ones that they should be consistent in their

review process, also in the management site team to -- the management survey visit, I mean to say, the major thing that came out of this was that it was not an effective management system for carrying out the program.

The area advisory group had not taken on the responsibility for direction of the program. Also, the program staff lacked consistency and, also, lacked a central direction and control of the funds.

There were several -- I'll hold the recommendation now and I'll go on to about their application.

In their new application, their overall goal was adequate as far as the written statement. They sort of used again the guidelines of the new mission policy; namely, that they would cooperate with other health groups, try to increase the availability of care, enhance the quality of care and work toward the reduction of cost of medical care.

Also, their objectives as written would assist to accomplish these goals, these being primarily to promote and demonstrate innovative delivery, assessibility, efficiency and effectiveness type of programs, to stimulate and support activities to help health providers to give better care and to also more effectively utilize available services, and they would encourage providers and enable regionalization of facilities.

Their priorities were, number one, was to increase the assessibility of health services to the urban underserved

and then those in the rural area. Number two was to increase the availability of service. Three was to work towards the prevention of disease. Four, to help with the distribution of health services, and, five, to improve the quality of care.

In their new application, there was still no indication as to what they used for a data base to define their goals and objectives, or also the process for what was determining that these were the goals and objectives for the program.

In the area of accomplishment and implementation, they have divided their program into three major areas. One being in health data and evaluation. Number two being manpower development and continuing communication. And three being health care delivery.

For the progress report for the health manpower development and continuing communication, I might add just briefly, too, that these are sort of set up into three autonomous units so that you do have Dr. Herbert heading the department or the unit of health manpower development and continuing communication. And between March '71 and '72, they did initiate four projects. One which is based at the Baltimore City Hospital on the management of intestinal stomas.

The objectives for this program was to provide teaching in self-care to patients. And between June and this past November, they had seen 430 patients.

The goal number two was to train intromastal (?) therapists, and for this, they had 35 -- for this group, they had 35 lectures and seminars. And Number B, they also had individual teaching programs with all the 430 patients.

The third objective was to develop an audiovisual package which would consist of slides and brochures, books and et cetera, and a T.V. program, and this is also in the process.

The second program that was initiated was a drug information center. This is a program that's aimed at giving information to health providers to reduce drug reactions in prescribed medication.

The third project that was initiated was the one on continuing education for non-Metro primary health care providers. And, here, this particular program had not been implemented yet, but they have completed the survey, determined what the needs were in the area of continuing education for the health care care providers in the non-metropolican area, and they have formed a regional educational planning committee which has reviewed the survey data and are now in the process of planning the actual program.

The fourth program was the preparation of the nurse pediatrics practitioners with the University of Maryland, and here again, they have recruited the faculty, have established committees and have developed all aspects for the curriculum.

The projected plans for the health manpower development and continuing education division -- continuing communication division is that they have recruited additional qualified staff and they have written several proposals to be implemented during the coming year.

They also have a research and survey analyst to do further information gathering for program development.

The overall new programs that they have -- in total, they have proposed six new programs; four which will be in the Baltimore area only and only two addressing themselves to the outside region.

The two that will concern the total region will be a kidney program and organs procurement and preservation program, and the other will be the emergency care -- I'm sorry. It's the hospitals discharge aspect data.

They do have a continuing program, three in the education or quality area that I mentioned previously. In the area of services availability, they will be continuing two HMO type of programs and the nurse pediatric -- pediatric nurse practitioner program for manpower.

For the health care delivery which is primarily the core or the RMP staff itself, it was pretty futuristic. In summary, they said they had been seeking funds and gathering data but that in the future, they will be putting more emphasis on programs in the non-metropolitan and rural areas,

and they plan to work with the new RAG and I'll explain about the new organization of RAG a little later, and also the policy planning information committee and that they will assist in implementing the inter-society commission on heart disease resource report.

Maryland was quite a difficult application to go through. It came out in three volumes and I have a friend whose theory is that if you can't convince them, confuse them, and I think they were trying to confuse me at points.

The other one, volume number two, was from the epidemiology and statistical center, and they did quite a detailed report and analysis of 25 studies. Thirteen were evaluation studies, twelve which were programs that were no longer being funded by RMP, and ten that was to be related to data information.

However, most of them were not geared toward data that could be used for planning for future programs, but I thought they were very good research analyses.

They also project doing three additional programs in the coming year. One will be on the medical emergency service. One to study the survivorship and quality of care, and this will be based on previous studies done upon heart disease, cancer and stroke patients treated at various types of hospitals.

It's planned for more or less a longitudinal type.

They're looking at a five-year survivorship. The third one will be the effectiveness of a coronary care unit and, here again, this is sort of a long range. They mention that there was quite an increase in the number of CCUs throughout the State of Maryland and so they plan to study the pattern of utilization of these coronary care units and then compare the experience of the current use with what had occurred several years before that.

One of the other criticisms of the previous site visit was that the RAG was not providing the leadership it should for program decisions and that there were a lack of regional and minority representations on it and, also, on the major committees.

They have improved in getting members from other parts of the state onto the RAG other than from the Baltimore area and they have also increased their minority representation.

They have also restructured the RAG so that in the future, it will be able to take more of a leadership role in the decision making and in program planning. However, this restructure did not occur until September and they've only had one meeting. So at this state, it's hard to tell just how this will come out, if they will be able to move into playing a more prominant role in guiding the program.

But they did create a ten-member Executive Committee

which will be meeting monthly and the overall, the total RAG will be meeting less frequently. They felt by doing this -- this was a recommendation they got last year -- that with the meetings being less frequent, then people in other parts of Maryland could participate in the RAG.

They have also created a health manpower and development and continuing communication committee. This is a 14-member committee which will be looking at data related to the needs for health manpower and continuing communication, also reviewing the projects for this area and making a recommendation to the RAG for their implementation.

They also have an epidemiology and statistical advisory committee which is a 13-member committee which will be serving the same type of function for the epidemiology and statistical center.

The policy planning and formation committee will be assisting in working with the director of the program to developm implment and coordinate and evaluate the programs. They will also be looking at the data that's gathered by the epidemiology and statistical center to be used for decision making about the program.

The core staff, as I said earlier, there are two major functions that I was able to pull out from their application. They have participated in a second Monday series which is one of the programs they had continued from a couple

years that's been successful with getting in some participation from people in other areas besides the Baltimore area, but it's been centered primarily in Baltimore, and that they will be seeking funds and also working out cooperative arrangements with other health facilities.

To try to summarize this a bit, the principal problems was that -- also from the staff observations -- was that there is inadequate program development by the staff, except for that Monday series, they seem to have done very little other work in getting any programs implemented.

They seem to sort of wait until somebody in either the University of Maryland or Johns Hopkins or maybe somebody in the city will come to them with a proposal and they will fund it.

And also the communications and the monitoring of these programs have not been very effective.

Another thing is that the committee structure, so far, has not been used in program development. It is their plans from their projection, again, that a new structure will help to facilitate the committee's function in this area.

Number three is the productivity of the epidemiology and statistical center. Here again, as I stated earlier, they have done some very good research analysis. However, their reports and their data have not been geared toward trying to get data to help them to decide what type of program to have

or to say to go out to approach other agencies to point out a need and what type of program might be effective. It's been purely more of a research thing that would be just general knowledge for anybody.

The other thing that, with this research center -- this is going back. I had trouble trying to keep separate what I was reading now and what occurred last year on the site visit. The two seemed very close, and I could observe very little progress in this past twelve months. It was like I was reading the same application all over again.

But when this came up in the site visit last year, the team did recommend that since the center was acting as more or less, say, research and data center for Hopkins, that they looked at maybe extending their services on a fee-for-service basis to other parts of the country and to become more self-sufficient.

There wasn't anything listed in the application about them getting any additional income or any plans for getting any sources of funds to keep the operation going.

The focus of the program still remains pretty much Baltimore-city oriented. As I pointed out earlier, of the six new programs that they are proposing, four of them will be for the Baltimore city area only.

One of their major programs that they are working on is for the development of an HMO and, here again, I didn't

quite understand what happened with this program when it came up last year and they asked for funding, they wanted over a hundred thousand dollars for this program.

Their objectives were not in the proved area that RMP was funding. They wanted money to not only look at possible quality in monitoring but they also wanted funds to establish a financial system and this type of thing. And this program was reduced in funding to allow them to carry out the part that would be approved within the overall RMP objectives.

They resubmitted the same program and they still maintain the six objectives they had from the year before. I don't know if you want to go into that now.

Another problem is that the coordination and direction of the program staff activity by the program coordinator is inadequate. Here again, I said they have like three separate units. The epidemiology and statistical center is a part of the School of Hygiene and more or less functions completely autonomous from RMP, including having their budgets and all their requests and what-not handled by the School of Hygien, and the coordinator of the RMP not being aware or knowing anything about their budget or it's just the final reports that he gets from them in the end or about their staffing, things of this nature.

Also with the manpower and development unit, although

Dr. Herbert reports to him, he has pretty much complete autonomy for the direction and development of that particular unit. So there's very little correlation between the health data that's coming out of the E and S center or the evaluation of on-going projects or an interrelationship between the health manpower development unit and the health care unit, so that everything is just like three separate programs.

Also, as I alluded to a little earlier and maybe someone else can pick this up a little bit better, is that the physical management is either minimal or nonexistent. This is from the overall management, by the business manager of the RMP unit.

Maybe I should stop here and let -- I have two backup reviewers, and you can go from there.

DR. SCHMIDT: Okay. Joe?

DR. HESS: I don't have a great deal to add. I think she's pointed out the major features. I would just reemphasize that as I reviewed this application, that there are three, possibly four, major problems which I saw.

One was the lack of systematic regionwide assessment of needs and leadership by the Maryland Regional Medical Program in developing new projects.

As mentioned, they seem to wait until something turns up and then they look at it.

Second is the lack of leadership involvement by

the RAG. They appear to be, according to the reports, almost totally dependent upon the technical review committees and, since, the RAG almost becomes a rubberstamp.

DR. SCHMIDT: Could you speak up just a little. The stenotypist can't hear you.

DR. HESS: Okay. And the third point was what appears to be ineffective use of this extensive epidemiology and statistics center. Now, theoretically, one would think -- this is an unusual resource. Most regions don't have the talent, nor are they expending the money that amounts to something like $166,000 a year going into this E and S center. And somehow, it's not having much payoff in the program itself thus far, although they do indicate that they have now appointed a committee to start digging into this data and see how they can begin to utilize it.

But it seems to me a rather late date to be thinking about this.

Then some question about the effectiveness of the mini-contract or feasibility study mechanism as it has been used in the past. Now, this may change in the future. But in looking over what has been used, it seems to me that in many instances, at least it's been the source of funding when people get in a tight spot, when money is running out from some other source, so that I think the management of that aspect to the program is another area which needs tightening up and tends to

reflect some of the looseness of the management program.

I will just comment on the renal disease proposal. This does look like a sound proposal. It's had the appropriate technical review as part of the state plan and Dr. Roberts in the local review here felt that it was satisfactory so that I have no questions about that particular aspect.

DR. SCHMIDT: Okay. Let's see. Bill?

DR. LUGINBUHL: I had a great deal of difficulty with this application. It is a well-written application and it is hard to know whether the changes claimed are actually changes in fact or whether it is simply a good job of merchandising, and I gather from the other reviewers who have had some on-the-scene experience with the program, that it may be the latter rather than the former.

I think the problems have been well stated. The progress that they claim in the application centers around the revitalization of the RAG with the appointment of a new chairman and vice chairman that the RAG is now assuming programmatic decision responsibility, that they've appointed some subcommittees and that these are beginning to work.

I honestly have no way of telling whether these claims are true or not. I think that it's fair to say that the application does not show any product of this revitalization.

The projects that are listed are quite limited.

I don't think that they are terribly imaginative or broad, but I honestly can't judge whether there may be changes in the offing.

They claim that they have made substantial changes. I would be very interested to hear from members of the staff that have visited this program as to whether things have changed in fact.

I must admit that I'm suspicious because the coordinator has been on the scene now for several years and it would seem to me that if he had the ability to bring about change, it would have occurred before this time.

DR. SCHMIDT: All right. Staff comments at this point?

GEORGE HINKLE: I might start out at the beginning and clear up a couple of points that Dr. Ancrum brought up.

DR. SCHMIDT: Slide the mike a little closer.

GEORGE HINKLE: I don't think it will.

One of Dr. Ancrum's concern had to do with the Project Number Thirty -- can't get it any closer. It won't stay.

DR. SCHMIDT: Just speak up. We can hear.

GEORGE HINKLE: This will do it.

It had to do with Project Number 36 which was an HMO project. It was sponsored with Johns Hopkins University.

Last year, council and committee were both concerned

about the type of activity they said they were looking for RMPS to support. We didn't think it was within our prerogative.

During the negotiation session, the MRPM personnel brought in a more detailed application of what they were going to do under that project.

Dr. Farrell of the HMO up in the DPTD, he looked at the detail and he determined from looking at it that they had some items in there for administrative support systems. Those are the things I think Dr. Ancrum was referring to, and also for some pharmacy patient profiles.

All of these, the expenses related to these two items had to do with computer cost and amounted to about $27,000.

So based on council recommendation, we told them they could not support those type activities. They concurred. We reduced their funding for that project by about $27,000.

Now, as the application comes in this time, it comes in exactly -- the narrative is exactly as it was before. It doesn't give enough detail to really interpret what they're talking about.

Also in their computer support areas, after last year's reduction, they reduced the computer data processing support request from down to $21,000. This application, they've jumped it back up to $41,000, almost another $20,000 increase which is almost what we reduced them last time.

So it could be, they've put these things back in but our advice letter specifically said they could not support them. It could be they're moving into other areas. I don't know the answer to that. But we have made a note to make sure that they're still aware that they cannot support this patient profile studies and the administrative support systems.

DR. SCHMIDT: All right. Dr. Ancrum, would you care to make a recommendation.

DR. ANCRUM: I had trouble with this.

DR. SCHMIDT: Well, there's always a moment of truth.

DR. ANCRUM: Well, they're still applying for triennium and I wasn't sure what they were offering for a program. They were still ready for a --

MRS. SILSBEE: Last year, the action was for two-year support, and this is the last year of that two-year support. So this is just one-year funding that they're requesting.

DR. ANCRUM: Oh, okay.

GEORGE HINKLE: Dr. Ancrum, may I make a statement.

Last year, if you recall, initially the site visitors only recommended one-year support, and we felt that they wouldn't have sufficient time to do all we wanted them to do so we made it two years.

DR. ANCRUM: Two years. I'm getting my numbers mixed up.

They were, for two years, and they've also requested an increase of funding over what was recommended from last year.

They recommended that they stay at one million two nine four for the two years, and they're requesting one point four million.

And as I said, I've had trouble seeing any real progress or any change in their plans from the year before, and I would recommend that they stay at the same level as they were this year to see if they can make some progress during the second year.

DR. SCHMIDT: All right. Then the recommendation is for a level of funding with advice, obviously.

Dr. Hess.

DR. HESS: I will second that recommendation. I think the major points of advice were made in the December follow-up letter from the management survey, but I think the language could be stronger than what was in that advice letter.

DR. SCHMIDT: All right. Dr. Luginbuhl.

DR. LUGINBUHL: Let me ask staff three simple questions. Is the coordinator any good? Is the RAG actually taking leadership with the new chairman and vice chairman, and have they done what they were told last year?

DR. SCHMIDT: I'll refer that to Dr. Ancrum.

DR. ANCRUM: Well, for one thing, Dr. Davens has been there, I believe, since the summer of '71. This region did have --

DR. LUGINBUHL: '70.

DR. ANCRUM: '70. All right. They did have quite a bit of trouble keeping a coordinator. He was the fifth, I believe, from since they were started in '69.

My impression from meeting him last year was that I thought he would be a good coordinator. As I said, I haven't seen very much progress from the application during this past year.

Also with the RAG, here again, the recommendations went out to them the first of the year. They didn't do that restructuring until September, so that they haven't had a chance to really function in this new organizational pattern yet. So whether or not it can work, I don't know.

Their application, the one the year before and this one have both been very, you know, in the future. They're always, "We will do it in the year coming up."

Now, I don't know how much longer we want to let them go saying that, "We will do it next year," or if we can give them some stronger advice that, you know, "Do it now or else."

DR. SCHMIDT: Dr. Ellis.

DR. ELLIS: We have been talking about opportunities for really developing programs for minorities and I did not hear here that there was a relationship with the Provident Hospital which is one of the few remaining supposedly good black hospitals that has possibilities for growth, and I just wanted to bring this up as a point of information.

I think that Baltimore is one of the cities in the country with a tremendous number of problems in the minority areas; high death rates in many areas, and, yet, they do have a core of people who can work together in a fairly good relationship between the races in some areas, and I just wondered if the Provident Hospital people have been brought in at all to this RAG and who are the -- and where is the thrust for the HMO? Is it only in the east side of Baltimore or are they going to the northwest as well where this hospital is located?

DR. ANCRUM: Provident Hospital, per se, was not mentioned. Their thrust toward the minority has been primarily with an HMO type of a group that's been developed there.

Can you help me out with the name?

GEORGE HINKLE: Maryland Health. They have the Maryland Health Maintenance Committee, Incorporated, which is doing the evaluation for their HMO. There's one in east Baltimore HMO that's referred to.

DR. ANCRUM: East Baltimore, yes. That's Johns

Hopkins. Pardon?

DR. ELLIS: Johns Hopkins?

DR. ANCRUM: So they have been helping with two HMO groups and sort of an ambulatory care facility. Provident Hospital was not mentioned but these have been their two major thrusts with the health service area toward minorities and the other one is planned for the educational components, two at Morgan.

DR. ELLIS: One other comment. I was just wondering how different the statistical information that's being given now from -- I suppose it's from Dr. Tabbetts office, that the school of hygiene, how this differs from the regular information which the City of Baltimore, in its board of health, has been collecting over the years, and if this is not an alteration in plan to help support an office which has been -- with people who moved out of the health department into this particular office.

DR. ANCRUM: Here again, the only thing that the application or the E and S report alluded to was that they did do quite a detailed study on throat cultures that have been run by the health department, using rheumatic fever as an indices, to see if there had been a change over time which would prove that there had been an improvement in quality of care.

The most of their work has been very pure research,

more so than seeing how it was going to relate to what they were going to do.

DR. SCHMIDT: Mrs. Flood.

MRS. FLOOD: As I look over the materials and hear the comments, I get the feeling that it's a Missouri mule that's already been hit with a two-by-four instead of Maryland and they still don't listen.

This application reflects 26 percent of their project dollars going into data systems as reflected by the printout and it just doesn't jibe that with their reduced funding as that clout that they've been given to get with it, they still come back with an application reflecting this much of their project dollars going into more data systems.

DR. SCHMIDT: Dr. Hess.

DR. HESS: Just to follow up on Bill's question earlier, I think it would be useful to have some comment from the staff.

The description on the site visit report of the coordinator for last year might be of some interest. It says:

"In the opinion of the site visit team, the coordinator, Dr. Davens, has provided a great deal of leadership to the Regional Medical Program of Maryland. He has been extremely sensitive to the new directions of Regional Medical Programs and has played a major role in terms of transmitting these new directions to the Regional Advisory Group as well as

other health-related institutions.

"It certainly appears that he has established a well-organized core staff and has given them the professional latitude to function in their areas of expertise."

They were favorably impressed by him on that site visit, but I think there are broader issues that come up here that we have to look at.

One of them is the advisability of Johns Hopkins continuing as a grantee organization and, furthermore, the representation of the two medical schools in numerical representation and the influence that they have exercised on the RAG, because what I am saying is, he may be a good man, he may be in a next to impossible situation the way things are currently structured, so the other alternative we ought to be examining is whether the effectiveness of this coordinator might be strengthened by some change in arrangement which would give him freedom and latitude to move, because it may not be entirely his fault.

DR. JAMES: It seems to me that we are now in the east coast of the country and the most developed area. What is it known as? As the highly developed industrial corridor of this country, and where, geographically, are located two very large and outstanding medical schools who have long traditions, especially Johns Hopkins.

I wonder whether or not there may be some duplication of effort in the kinds of demographic -- no, the kinds of collection of data which doesn't really meet the needs of the people because of the predominance. In other words, Dr. Hess, I think I would have to say yes to what you're speaking of, primarily because you have in this situation Johns Hopkins who has a long tradition of contributing to technical developments in the area, in the medical field.

It would seem to me that from what I have heard, that most of the program is predominantly centered around Baltimore while the rest of the state seems to go wanting so that a redirection from the hierarchy or from a new approach from, say, just letting Johns Hopkins out of the picture, but perhaps using another source as a grantee organization may then make a picture more clear in terms of the kinds of material that is attempted to gathered that would have a relationship to the needs of the people in the community outside the area of Baltimore.

Not stating, however, and I'm not foregoing the

thought, however, that certainly, there are probably unmet needs in the Baltimore metropolitan district as it is in all metropolitan and urban areas.

I'm not suggesting that these problems be foregone.

I think what I really am trying to say, and it's a little bit difficult for me to put it into succinct words, perhaps the tremendous technical ability that Johns Hopkins already has, and with the availability of the work that they do do, maybe overshadows what an RMP might do in a community.

In other words, I think that what we're really saying here is that there's so little progress being made, maybe one should look at the State of Maryland and to see whether or not our RMP is really needed at all in that community.

If it is needed in that community and that state, then it should be possibly centered outside the city of Baltimore, utilizing the two universities more or less as consultant services, but to give them wider latitude in being more independent to develop a program rather than depend upon the strong influence coming from the universities.

DR. SCHMIDT: All right. We do have recommendation then for level of funding. It is obvious that the advice letter from before, and the advice being given to the region, must be given again and given more strongly, and even to the

point of, you know, saying that you really should get out of this sort of a thing and, again, it's going to come up with at least one more area in which there is a kind of a one-year warning on this, and then I suppose going back and looking at it again.

DR. ANCRUM: Could I add to the possibility of what Dr. James said about them thinking of another grantee? That's one of the things I jotted down in my notes.

DR. SCHMIDT: Well, the other grantee issue is very, very difficult and I'm not -- I think that all a review committee can do is to instruct the director of the Regional Medical Programs to take a good hard look at that.

But in this sort of a negotiation, I believe it's best conducted under the careful auspices of the director of the program, and I think that this will be conveyed, that we are concerned about Hopkins and its interest being a little bit too limited for what is needed in the Maryland Regional Medical Program.

I think that the city of Baltimore is in great and dire need of a Regional Medical Program. You go over to the eastern shore, and I know very well it is.

MR. CHAMBLISS: May I just inject here, the fact that this RMP is in one of those so-called complex metropolitan areas. This is an area that the RMP has had, as we all know, great difficulty in operating. It seems to suggest here that

rather than really gripping the real health problems that lie around it, it collects data.

I'm wondering how we get at this fundamental problem. We need you to dig into this, to show us some new pathways not only as a staff but so that we can impart this to the RMPs.

We have been very concerned with the issues that you've been touching on for some time here and your discussion here is most needed.

DR. SCHMIDT: Well, before, Bill, you talk, we did, just thinking about yesterday, we can indeed, you know, put a region on probation, number one, and suggest to the region that the concerns are, even as basic as the grantee organization and that these things must be answered within one year or the total funding will be jeopardized and this is an approach that we kind of gravitated through. Bill.

DR. THURMAN: If my memory doesn't fail me too much, we spent about two hours last year on Maryland around two areas. One of them was the HMO and the other was the E and S.

And as I recall the discussion, and certainly in Dr. Margulies advice letter, the HMO bit, we said forget, in essence, and you get the feel that it's coming back. And we asked for a lot better understanding within this one-year period of time of what E and S was really contributing to Regional

Medical Programs in Maryland.

So that even before you had the opportunity to speak, Mr. Chairman, that was going to be my comment.

I don't feel that we can vote yet on this until we have a better understanding of the continuing impact of E and S on this RMP.

Until we do that, I would be opposed to continuing level of funding.

MRS. SILSBEE: Last year after the review, the powers that came into Rockville sat down with Dr. Margulies and staff to go over the advice letter and the advice, and a lack of the power structure coming in was from the Regional Advisory Group.

The discussion about the E and S center was one in which it seemed, again, that they were on the verge -- the data that had been collected was superb, the base line data that would help that Regional Advisory Group decide where they wanted the program to go throughout the state.

And I think the issue at this point is, has the Regional Advisory Group taken advantage of that data and proceeded?

DR. SCHMIDT: Joe.

DR. HESS: I'll have to confess. I haven't read every page in this volume which is all E and S data, but several pages that I have reviewed, I would find very difficult

in using that if I were on the RAG because it is not -- to a large extent, it is not broken down into geographical areas or into a form that would be very useful if I were trying to plan to define and then plan for the health needs of the region.

And it seems to me that there is some conceptual difficulties underlying the gathering and the presentation of this information, and I think that's where -- you know, the technical skills are there but the conceptual rationale, just all whatever you want to call it, is lacking as it applies to an RMP --

MRS. SILSBEE: And there's no evidence that the Regional Medical Program staff itself has done this translation.

VOICES: No. No.

DR. HESS: You'd think if they were trying to impress us, as the review committee, you know when they send this in, that they would put it in the simplest, most salient form so that you could see clearly how you could go from step A to B to C, but that just isn't the case, at least in my analysis. I don't know what you thought.

DR. ANCRUM: This is what I meant when I said it's a very good research but it's more general as somebody's been doing a term paper or one who wanted general information could use.

I did spend quite a bit of time on that report, and

I don't think I could use that data as the way it's entered right now, to really use a base for making a decision within a local area.

VOICE: At least we did help you.

(Laughter.)

DR. SCHMIDT: I've always felt a little bit anguished at Regional Medical Programs in metro D.C., Virginia and Maryland doesn't have a model RMP. I was thrown out of the State of Virginia early on for even talking about it, and it's just too bad we don't have -- you know, you've got to be able to point with pride.

DR. THURMAN: If you came back, you would probably still be thrown out. Not referring to you as an individual, referring to the State of Virginia.

Then, on the basis of this discussion and thinking back to last year's discussion when we really had specifically requested that the E and S information and support be directly related to the mission of RMP in Maryland and having some concern, again, I would not speak against Dr. Davens, per se, except to say that I'm sure that the advice that trickle back to Maryland, not being that far away, was reasonably good and we've seen little response to it.

I would offer a substitute motion specifically related to one of two -- no, that's bad. I can't do that. I would offer a substitute motion that we not continue level

funding but that instead, we cut them back at this point and time with a site visit in the very near future and that level funding be for no more -- that cutback in funding be for no more than a year so that the site visit can be accomplished in that period of time.

And that a specific component of that cutback be related to cutting back E and S until such time as its relevance to RMP programs within Baltimore and the remainder of Maryland could be demonstrated.

DR. SCHMIDT: All right --

DR. THURMAN: Everybody has just reminded me that I did not give a level of funding.

DR. SCHMIDT: Right.

DR. THURMAN: I've forgotten what your -- Gladys, what your recommendation was.

DR. SCHMIDT: Her recommendation is one point two nine four nine six oh.

DR. THURMAN: Okay. I would say then if it's one point three roughly, I'd say let's cut back to one point oh with the letter of advice and the intent to visit.

DR. SCHMIDT: All right. This substitute motion is seconded.

VOICE: That includes the kidney.

DR. SCHMIDT: That would include kidney?

VOICES: Yes.

DR. SCHMIDT: All right. Dr. Luginbuhl.

DR. LUGINBUHL: This program, I think, poses a very difficult dilemma. I still don't believe my questions have been fully answered.

It seems to me that the Regional Medical Program has three potential sources of leadership. One is in the staff and particularly in the coordinator. The second is in the RAG, and the third is in the grantee organization.

And ideally, all three are strong and are concerned and effective, but I think that sometimes we're getting by where only one is in that position.

I'm concerned that in Maryland, maybe none of the three are really strong, concerned, well organized. Who's going to worry if the budget's cut back to a million dollars? Who is going to take the leadership in changing the program?

They've been warned before. Pressure has been put on. It seems that not very much has happened.

MISS ANDERSON: Put them on probation.

DR. LUGINBUHL: Who is going to take this, "What's our level? What's our handle for bringing about change?"

To me, this is an area that desperately needs help, not just outside of Baltimore, but within Baltimore. I wouldn't even be bothered if the program were in Baltimore if it were doing a good job. God knows that their needs are there, but I don't see how we're going to get a handle on this

at this point and time, and I still would like to have my question answered.

Is there strength in any of those three elements that we can build upon to improve this program?

DR. SCHMIDT: Well, I wouldn't like to recycle this. You know, you got as good an answer I think as the people who reviewed the thing and the staff could give.

The coordinator seems to be good, was the mean answer I would get. He has carried to the RAG the message. He's doing what he can under the circumstances, I would guess. It's hard to go up against Hopkins.

One of the funniest things that ever happened in the Regional Medical Programs happened in the early days of Hopkins when Tommy Turner was Dean and C. C. Conrath and Elsa and Rebecca went up to meet with the instigators of the program in the august halls of Hopkins and went to the meeting room and opened the door and there was the male contingent led by Tommy Turner sitting on the table, and around the table and the three ladies -- this is early on in the feminist movement -- and the three ladies were told where the women's bathroom was. It was assumed they were looking for the bath.

(Laughter.)

DR. SCHMIDT: So they've come a long way since then.

(Off the record discussion).

DR. SCHMIDT: There is a motion on the floor, one year at one million --

MR. TOOMEY: I also am concerned just as Dr. Luginbuhl is, and I'd like to amend the motion, if I may, to so state that this RMP will be on probation for the period of one year with the million dollar funding.

DR. ANCRUM: I would second that.

DR. SCHMIDT: All right.

DR. LUGINBUHL: Could someone specifically comment on this RAG. Has it been improved during the last year? Is the new chairman and vice chairman, are these people an improvement? Are they a base of strength?

DR. SCHMIDT: Dr. Ancrum.

DR. ANCRUM: I don't know, unless -- the staff did make a management visit in September. Whether or not they met the RAG, I don't know.

The other thing is that this restructuring only occurred in September and happened like from January, and they didn't do it until September.

DR. LUGINBUHL: When they wrote the application?

DR. ANCRUM: Yes. So that you don't really have anything that you could really evaluate to say, well, they have a group that can work or cannot work, and you have no way of saying they have done anything except to write that they have made this reorganization.

MR. CHAMBLISS: Let me take just a shot at your question, Dr. Luginbuhl, about the RAG.

We did, in fact, receive a letter from the coordinator, I believe in the last ten days, indicating that a new RAG chairman had, in fact, been appointed and that a new vice chairman had, in fact, been named.

That vice chairman is the assistant administrator of the hospital to which Dr. Ellis referred, Provident Hospital. That's a spanking new hospital serving the minority community at Baltimore and this would seem to indicate that they are aware or concerned about some of the key health issues in Baltimore.

Now, as to the strength of those two people and what they can do on an immediate basis in keeping with the status of this RMP is something I would think to be seen.

DR. SCHMIDT: All right. We will vote then on the move to amend, which is to add the probation message to them. All in favor of that say aye.

(Chorus of ayes.)

DR. SCHMIDT: And opposed, no.

(Motion carried.)

DR. SCHMIDT: We're back then to an amended substitute motion which is one-year funding at one million on probation, strong advice, a site visit soon.

MRS. SILSBEE: I didn't quite understand when the

site visit was to take place.

DR. SCHMIDT: It was as soon as possible.

DR. THURMAN: If I might speak to that, I think if -- going back to what Mr. Chambliss just said, that they have a new RAG, maybe they're going to rattle the bag a little bit, then I'd be willing to put that off until such time as -- say, give them a year at this one million funding with probation, but some time before a year from now, we'll be looking at it again. There would be a site visit.

That's a personal opinion. The rest of the committee may not agree.

DR. HESS: I would agree with that. I think an early site visit --

DR. SCHMIDT: All right. We'll move the site visit then. Are we ready for a vote then?

MISS ANDERSON: Yes.

DR. SCHMIDT: All right. All in favor, please say aye.

(Chorus of ayes.)

DR. SCHMIDT: Opposed, no.

(Motion carried.)

DR. SCHMIDT: Okay.

DR. THURMAN: I think it's going to be most interesting to see how council handles review committee this time around.

DR. SCHMIDT: Let's move on to New York Metro.

The primary reviewer, Dr. Thurman backed up by Dr. Kralewski. Dr. Thurman.

DR. THURMAN: Going back to what Dr. Scherlis had to say yesterday, he visits and then coordinators resign.

When they heard we were visiting, he resigned, so that I think that paints a little bit of the picture with which we were dealing. We were fortunate in having Alex McPhedran who had been from the council, who had been involved in the previous site visit, a very strong RAG chairman, and George Williams, Bill Grove from the University of Illinois who is related to the same kind of grantee relationship with the RMP that was, at that time, existing in New York, and lastly, Mrs. Thieme from West Virginia RMP who handles their fiances.

We were backed up by Bert Kline, at the end of the table, Waddell Avery, Bob Shaw from SHEW Region II, and again, fortunately, for us, Ed Hinman was with us to discuss the whole area.

I think that I'd break down the problems in metropolitan RMP somewhat by saying that we went knowing that their entire program had just fallen apart so that part of our site visit was to see if there was anything salvageable and, if so, what kind of advice we could offer.

Historically, there's been a very poor grantee

relationship in that the coordinate group of the medical schools in metropolitan New York had come together to serve as the grantee.

This grantee had, in many ways, not related well to the RAG. As much as we could make out, we did not meet the resigned coordinator, but as much as we could make out, in many ways, had not related well to the coordinator.

A classic example is outlined in Mr. Kline's cover letter in which following resignation of staff professional in late '71 and early '72, the grantee actually said, "Don't recruit anybody to replace them."

The second point that took much of our time on the visit was that the grantee was totally unwilling to accept the new policy enumerated from RMPS in Washington in reference to the RAG grantee policy relationship. The feeling was so intense against that policy that a letter had been directed directly to the assistant secretary of HEW asking for an exception and then 30 days prior to the time that we arrived, the grantee had more or less said that we want to resign as grantee and they also requested that our site visit be delayed.

So that we came to the grantee in that kind of an environment and it did not improve, in essence, during the time that we were there.

Specifically, Bill Grove came to try to help in this

readjustment and re-relationship and I think that you'll notice in his report which is a part of our report that at the end of our meeting, he said that we should allow the grantee to go ahead and resign.

So that despite the specific task which was assigned to him, both Washington and by our committee, he came to the conclusion that we should allow the grantee to resign.

Second major problem, of course, was in the coordinator. In essence I think, speaking for the entire site team in general, we had the impression that this was a one-man show. The deputy coordinator was not involved in decisions, fiscal questions as to how money was spent, things like this were somewhat vest pocket operations. I do not mean to imply that they were illegal or improper from the standpoint of accounting, but were vest pocket decisions related to his gut feeling about what should and shouldn't be supported.

He had a poor relationship, in general, with the RAG. They were not involved in the decision-making process. He chose what to tell them and what not to tell them. And he also requested that the site visit be delayed. And when that did not come about, he resigned eleven days before we arrived.

The more you heard about him, the more I kind of expected him to jump out of a closet with tails and a horn.

It just didn't work out that way while we were there.

Speaking to the third problem which was with the RAG, we had a very interesting chairman of the RAG who had just accepted -- despite the problems that I've enumerated -- had just accepted reappointment as chairman: strong, interested, basically didn't understand the rules of the game as related to RMPS in a way. He wanted every cent possible of federal money for New York City and its health problems and looked at RMP money not so much as developmental or conduit money but as actual-dollar-spent money to help deliver health care.

He didn't realize the depths of the problems within their own organization. He had never become involved in their turf problem, which I'll speak to in a moment, to any great degree. He did not recognize the staff's attitude and the staff's difficulties. He had been kept somewhat in the dark by the coordinator without really realizing it himself.

He had not been included in the communications from RMPS here to the organization, and all of this -- and yet I still say that he's a very strong individual. He was running the RAG and he thought he was running his relationship to New York Metropolitan RMP much as he had run his corporation in the past.

He was president of the board and I think that if

there was one useful thing that came out of our visit and the feedback session associated with it, it was that I think we changed his perspective in what the RAG should be and how it should be involved.

Another weakness of the RAG in general, that despite New York, Metropolitan New York and all of its problems related to minorities and their cares and concerns, there's minimal consumer and minority involvement on the board. I think that this is partly again the reflection of the attitude of the RAG chairman in feeling that there wasn't much need to really involve them because everybody understood that RMP was out to help them.

I'm not so sure that everybody understood that, but that was his feeling and there was minimal involvement and all through our relationships with TCPs, review process and everything else, it became clear that they often considered minorities and consumers to slow down the process of helping the people, rather than having them involved.

But I would again strongly emphasize that the present RAG chairman is a very strong individual who is educable and was very receptive to the feedback situation.

The RAG used to be much larger than it presently is. It's presently 52 people. He believes that you can use a 52-man RAG as a functioning body and, although he somewhat denies it, the priorities and screening committee, in essence,

is serving as an executive committee because he does not want an executive committee in that sense of the word.

In reference to goals and how decisions are made, they've established their goals as three: health care services, health manpower, pool improvements and the quality of care. And they made this decision reasonably early, and the great majority of their projects have since been directed toward those goals, and that's worked out reasonably well.

They established, in the early days of RMP, their RMP because this program was not established until 1967. But they established early, technical consulting panels which were made up not only of individuals from medical schools but also from practicing physicians in the City of New York who have particular expertise in a given area.

These panels were excellent, obviously most of them initially were categorical, but as the mission statement became available to New York Metro RMP, they developed other TCPs along the lines of the mission statement. So that they've been touch with the times in that sense of the word.

The one thing that they didn't do and that has hurt them considerably, as far as visibility and acceptance in the community as the mission of RMP change, they did not bother to inform the TCPs related to cancer, heart disease and stroke, and we ran into some very, very bitter individuals from the TCPs in saying that they'd heard nothing from Metro RMP

for several years.

So that it was this kind of a hard feeling in the medical community and in the consumer-related community.

I think that they've done reasonably well on their TCPs, in particular, and also in their RAG in having representatives of other than physician-related providers involved, and this was particularly true in the TCP statement. But the gist was zero communication, and again, I, and not only myself, but others felt that part of the zero communication with the LTCPs, no longer functioning and active, was that the coordinator just decided he didn't need them anymore, didn't want to disband them for fear of hurting their feelings, so he just didn't talk to them.

As the new staff came on, nine of the twelve staff were within four months of our arrival there, they did not understand the situation either and they didn't bother to go back and try to relate old TCPs to new. Some of the new TCPs, particularly related to ambulator care improvement, were rehashing or did not recognize it, but were rehashing old projects that had been thought of by the categorical TCPs and no one was relating the two TCPs to each other. Until we got in the room, some of them didn't even know what the others were doing, so that the site visit survey served that purpose.

And, again, I would emphasize that these TCPs have done their job quite well. Some of them -- and this was going

on while we were there -- the respiratory TCP was right in the middle of a study evaluating needs throughout the entire Metro area and they had continued to do this, some of them without RMP support.

Gradually, the TCPs have moved away from the medical schools and have become more community based and, again, as I said before, they have a very broad base of representation of TCPs.

TCPs are actively involved in the review process and what happens is that a letter of intent is directed to the priorities screening committee which is a committee of the RAG and, in essense, is the executive committee in many ways of the RAG, that letter of intent is evaluated by the priorities and screening committee as to good or bad.

If it's bad, they say, "Don't bother putting up a grant application." And if it's good, the staff member is assigned and then a grant application is actually worked through with the staff member. It then goes to the TCP for its reaction. The applicant is in the room with TCP during discussion of his application and then is excused at the end.

Sometimes that has fallen down in that he was excused at the end, the decision that was negative was made and he was never informed. But in other instances, the TCPs have been careful to inform him if things didn't go well.

The TCP approves the idea. It then goes to the RAG,

is presented by the TCP chairman in general. So that there's a very smooth and well functioning priority relationship and relationship to the TCPs that have laid out fairly good plans for Metro RMP.

Speaking to the staff problem, as I indicated, nine of the twelve were new. Unfortunately, again, the resignation of the coordinator just before we arrived, put the staff in the position when we walked in the door of polarizing for and against the man who was acting coordinator, and again, we were often asked to adjudicate disagreements in the two days that we were there between the members of the staff.

And I think that all of us were of the opinion that there were some talented people on the staff. I think the future direction of Metro RMP may require that to some of that staff be said either, "Get with the policy or get out," because the polarization was quite noticeable to all of us.

The morale is quite low as one might expect. In the proposal before you, they have requested several new staff positions, particularly beefing up the evaluation area because that is one of the weaknesses that they had in the past.

The other thing that was noticeable to us as a site team was that they have not used their staff in the areas for which they were recruited at times. But again, I think that partly relates to the rapid turnover in that one person never

knew who'd be in the next office the next day. So that that's created some problems.

I think, again, that the relationship to the acting coordinator is most important and, certainly, will be very important in reference to retention of the good people of the staff if they don't too quickly polarize against him.

They have a turf problem not unlike Mr. Toomey has discussed in that Metro RMP covers all five boroughs or counties of New York City and three upstate counties.

One of the five boroughs of New York City, for those of you who are not familiar with the metropolitan area, one of the five has always felt it's never been a part of anything and it never developed a level of civic pride. That's Queens.

The Bronx, it was entirely different. Brooklyn's always been very different. But the Queens has always felt left out of everything, and we really walked into that one in that, in essence, anything that someone proposed for health care delivery programs in Queens, it was medical school related, created a mediate problem because Queens has been pushing hard to get a city medical school in Queens itself. So that they argued back and forth a fair amount about "What are you going to do for Queens?"

And the vice chairman of the RAG is one of the proponents of telling Queens what to do, and this has created

some real problems. But at the session with the RAG, the representative of Queens was there and, in essence, he reflected the feeling that Queens had been left out and they hoped to be involved but they didn't want to be told what to do medically.

I think the upstate counties have also felt somewhat left out, that the RMP dollars were primarily directed to metropolitan problems. There's been a change in attitude by the coordinator before he resigned in that he was beginning to actively look toward the upstate counties. But there still was a feeling of being left out, which was reflected to us several times.

The last problem -- not the last, but the other problem that we ran into that was terribly concerning to some of us was the whole business of the finances. The money goes to the grantee and then from that point on, the man who's business manager of the grantee is also business manager of RMP and they are switching money back and forth to pay for X number of hours that he's working for each.

The accounting certainly was all right, as indicated in the management assessment document available to you, but the man who was responsible for the money did not have a primary feeling that he belonged to anybody and he kind of floated in between and he was often vest pocketed from the standpoint that somebody, particularly the coordinator, would pass him in

the hall and say, "I think that it's a good idea for X to receive $48,000. Issue him a letter of award and set up an account." And that's kind of the way things were going and this was a terribly good man. Several of us spent a lot of time with him, and he desperately wanted to be included in RMP and not in the grantee, but he had never been able to work that out.

Because he had no authority on either side of the fence, one of the major problems with Metro RMP has always been that they had unspent monies, and nobody knew where the monies were until the end of the accounting period and there was no attempt to try to switch them to other areas.

With the financing situation, one of the major concerns has been that the impact of the new thrust of New York Metropolitan RMP had been too much directed toward renovating out-patient facilities in a series of hospitals. And the man at the accounting level was very concerned about that because he didn't feel that he could necessarily justify grant funds, as he understood them, to renovate ambulatory facilities.

So that I think that's a general rundown of the problems as we saw them when we arrived. The vice chairman of the RAG promptly laid us out by saying that he understood we were there to look at the problems of New York Metropolitan RMP and there were no problems. And so that he didn't really understand why we were there. That put us off to a very good

start, and from there on, I think that we served the purpose, primarily of listening which, in essence, was psychotherapy because they all needed it.

I think that our evaluation of the projects as presented, there was no increase with any great degree requested in core staff and office expense, but they were asking for additional monies for contracts and grants. They've used the contract mechanism a lot.

Just to give you a feel for the figures, and I will not make a recommendation at this point and time, for the period of January 1, '72 through 12/31/72, a one-year period, they were funded for $2,235,000. For a subsequent one-year period, they're requesting $3,310,000, so that this is the level at which they've been operating and, again, I would emphasize that they have related their projects well to their previously accepted and established priorities.

the type of projects, such as the Bronx manpower consortium, where they are trying to find health care delivery people of an entirely different type from the usual to attack the health manpower problems in the innercity, that was well structured to what the priorities were and how they were accepted.

Similarly, the improvement in ambulator care, which the TCP on ambulatory care was trying to address in a meaningful way and had related their priority structures to the RAG, from

that standpoint, is reflected in the projects that are suggested for funding.

So that despite this long list of problems and despite the internal stress and strain that has been in New York Metropolitan RMP for quite a while, they have continued to move toward the goals related to the mission statement and have moved reasonably well.

I could certainly not defend the quality of some of the projects well, but again, as far as extending themselves to meet health care needs, the Metropolitan New York, they certainly have moved toward that quite well.

Prior to recommendation, I'd like to have the others comment, if they would now.

DR. KRALEWSKI: I'll keep my comments limited. I haven't visited this program, either this time or in the past, so my comments are from the grant application and the things that I could glean from that application are far outweighed by the insights brought back by the site team.

Suffice it to say, I think this is another candidate for our receivership kind of approach.

I think in looking at the projects, that they show some promise. I think in looking at RAG, they've got some real talent on the Regional Advisory Group if they can bring that talent together and if they can get someone to assume the leadership, and I think there's some good talent on the

program staff, the way it would appear.

In many ways, you know, the RAG is large but, again if they get it organized properly, I think they can turn it into great advantage.

I suppose that a program such as this, with so many problems that they had, in a way, it's an advantage for them to have everyone resign as they're doing and have a chance to restructure the whole thing. I think our question now is, how can we help them do just that?

With that all, I'll cease and desist.

DR. THURMAN: Mr. Chairman, I would like to have Mr. Kline comment if he might because he's been very much tied up in their problems.

DR. SCHMIDT: Bert.

MR. KLINE: I think I can lend very little to the report that Dr. Thurman gave. I may give an update if that might be of any interest.

There was concern, as Dr. Thurman indicated, on the part of the program staff who inherited Dr. Aronson, the previous deputy, as the interim director, and there was this polarization; however, in the past three to four weeks, there's certainly evidence that Dr. Aronson has grabbed ahold of that staff and resolved some of the internal problems.

He has come up with a reorganization, internally. He has given each organizational function a description of

what it is he expects and it's quite clear and to the point. He has given each individual an assignment and, all of a sudden, the internal turbulence seems to be dying off.

Dr. Aronson, again, somewhat different from his predecessor, is beginning to relate to the Regional Advisory Group, the CPPE and other important aspects of the program. He is also somewhat different from his predecessor from the standpoint that he is beginning to make decisions. He's beginning to find out where the dollars are, who's got them. If they're being spent; if not, why not, and beginning to reprogramming and rebudgeting within, and he's doing this, from where I see at least, in a reasonably effective way.

Since the site visit, there seems to have been a significant upturn, if you will, in terms of what the program is currently doing. Popper, the RAG Chairman, who is identified by Dr. Thurman as a point of strength, has come here to RMPS headquarters and has pursued a number of issues to, if you will, educate himself and also to speak very specifically to the new grantee and some characteristics and to explore this with some people here and to get some help.

So all things looked at subsequent to the site visit have been, to my way of thinking, leastwise, very positive showing, I think a positive impact of the site visit.

I think that both Mr. Popper and Dr. Aronson are

beginning very firm, positive movements.

DR. SCHMIDT: Okay. Thank you. Dr. Thurman.

DR. THURMAN: Thank you, Bert.

I think there's one question that still has not been resolved and that was one we were just discussing. That's the resignation of the grantee.

Despite all of the problems that we found, their request is on the left-hand side of the chart up there, $3,310,000 for the year beginning May 1.

Our committee came up with the recommendation of $710,000 for office, have drawn lines through the $100,000 for development, basically, and then operating monies of $1,200,000. So that we are recommending -- I would move that we approve for them, assuming that the grantee situation will be resolved to the satisfaction of RMPS, $2,010,000 for the period May 1, '73-April 30, '74.

DR. SCHMIDT: John.

DR. KRALEWSKI: I second that.

DR. SCHMIDT: All right. Then we do have a motion that's seconded. Miss Anderson.

MISS ANDERSON: Bill, do those crossed out lines mean you're going to disallow the developmental component?

DR. KRAMER: No. It's just that, in my mind, in reference to the discussion yesterday, I don't think we know what developmental component is anymore, so that --

MISS ANDERSON: Okay, so if I add that, it would make nine. It makes 19. You put one million nine if you don't include it.

DR. THURMAN: Yes. It'll be one point nine. I just put those lines there because our site team, basically, recommended $100,000 for developmental component and I thought that I ought to reflect that and then we'll just have to decide -- not "we." Someone has to decide what happens to developmental component.

MISS ANDERSON: Are they actively recruiting a new coordinator, do you know?

DR. THURMAN: I can't answer that, active recruitment of the new coordinator. The committee was -- Mr. Popper, who is chairman of the RAG, told us that he would have a committee as soon as he had the opportunity to get back together with all of his other people.

MR. KLINE: The only information I can lend along that line is that the steering committee of the grantee and the Regional Advisory Group have met since the site visit, they have appointed a search committee for a new coordinator. It consists of two members of the outgoing grantee, if you will, and three key members of the Regional Advisory Group, including Mr. Popper.

DR. SCHMIDT: I was just clarifying the status of the developmental. We can, indeed, approve $100,000 of

developmental funds.

Well, I gather my overall question was, is there anything there salvageable. And the overall answer is, yes.

DR. THURMAN: Yes. I think that we're hanging our hat on Mr. Popper and a staff that's reasonably good, a deputy coordinator who has become acting coordinator who may seriously have difficulties if he doesn't become coordinator in readjusting to the system.

If I had to guess, I guess he would resign.

But I believe it is salvageable. I think that the loss of the grantee is going to be to their advantage, and any number of times several of us had one meeting with the deans of the medical schools, separate from everybody else, both in that meeting and in other public meetings came out over and over that the New York medical schools would continue to support RMP in every way possible and contribute to it and their departure as grantee should be in no way construed as a desertion of RMP in Metro New York.

DR. SCHMIDT: All right. Are you ready for the question?

VOICE: Would you repeat that, please.

DR. SCHMIDT: The motion then is for approval at a one-year level of $2,010,000 broken down as you see it on the board: seven ten, core; one, development; and one point two recommended for project.

DR. LUGINBUHL: Why are we breaking this one down?

DR. SCHMIDT: We really aren't breaking it down. That's just in order to understand the level. So it's at two zero ten. But it's helpful in understanding, explaining the rationale for the amount.

If no one wishes the floor then, all in favor, please say ays.

(Chorus of ayes.)

DR. SCHMIDT: And opposed, no.

(Motion carried.)

DR. SCHMIDT: All right. Thank you once again.

Is it the wish of the com mittee that we break for lunch at this point or would you like to go ahead?

The cafeteria closes, I understand, at 1:30. They usually run out of pumpkin pie about ten to one, and they run out of salad about five after one. They run out of other goodies about one fifteen.

Joe, how long are you going to be with Tennessee Mid-South?

DR. HESS: Very short.

DR. SCHMIDT: All right. We'll move on to Tennessee Mid-South and if we have to break for lunch, we will, before they run out of pumpkin pie.

DR. HESS: I think this can be possible taken care

of rather quickly because, ordinarily, this region is in triennium and, ordinarily, would have been handled only by SARP, except that there's been a little change in funding, in the allocation of funds, and there was not previously awarded a developmental component authority and that question has been raised.

And then the second issue has to do with the renal project in this application so that what I'll try to do is just to summarize in a very general way my impression of what's gone on and what the issues are and then I think Dorothy can supplement that, and then if we have to answer further questions, we will try to do so.

This region includes the eastern three-quarters of Tennessee and the southern borders of Kentucky. It is currently completing its first year of triennial status and this is entering into the second year.

A number of suggestions were made as a result of the triennial review. There has been a number of visits to the region or review process verification with site visit in October '71, anniversary review in '71, and then a management assessment visit in '72, and out of these, a number of suggestions have been made and most, if not all of these, have been complied with.

So that what I'm trying to say is we're not dealing with a Missouri mule here. We're dealing with, what at least

appears to be, a response of region. And the assessment by the staff anniversary review panel has been basically favorable in terms of their response and the way things are going.

I would like to see if we could go to the budget questions and just point out for you what the issues are. If you'll turn to the budget sheet which is the third page, you can see that in the current year, 05 year funding, there was $385,000 that were used for contracts. Part of that has gone into developmental component. There's a little increase in program staff. But, really, it's a sort of a different way of using developmental component.

They are approved at the level of two point three eight million. They're only requesting two point one six six which is the same as their current year. It seems to me that this was a prudent kind of management decision and gives me confidence that they really had a handle on what they're doing and that they're trying to use their money wisely and effectively.

The kidney project was submitted at $176,439. On the basis of the staff review, it was felt that this could be reduced to a hundred and fifty-five, -fifty-six thousand dollars, and that the proposal itself was in keeping with all the guidelines for renal disease proposals.

So that I would like to suggest that I support

the recommendation that they be allowed to have a developmental component of this magnitude.

I might mention that their plans for this developmental component include 34 activities ranging in cost from $1500 to $75,000, the most expensive. The average cost is about $6300. So that it seems to me that they're intending to stimulate a great deal of activity by the use of this money.

DR. SCHMIDT: Okay. Dorothy.

MISS ANDERSON: Why, I concur with what he is saying. The part that I'm concerned about, I thought the kidney proposal recommendations were good. But their continuing education program has continued to be the same as it was many years ago, and there's nothing really innovative about it. It's the same fragmented type of individual discipline education, and I think this area needs to be looked at and maybe certainly reduced or that type -- eliminated, unless they can do something that's innovative for the program.

DR. SCHMIDT: All right. Would you phrase a specific motion then?

DR. HESS: Yes. Well, I would like to move approval of the funding request as submitted which is for two point one six six million dollars, that the recommendations of the staff anniversary review panel which are outlined here be approved, and there are just a couple of additions to that.

They point out the need for more minority representation for -- more nondivider representation on the RAG. In addition, something they should do continuing work on, there is a vacancy in the director of planning evaluation. I think the advice letter should encourage them to try to fill that as soon as possible. But, basically, their core staff is fairly complete.

DR. SCHMIDT: I understand Miss Anderson seconds that.

MISS ANDERSON: I do.

DR. SCHMIDT: She does.. Questions or comments then to either of the reviewers. Yes.

MR. LEE VAN WINKLE: What was the funding level on kidney in the discretion of the committee.

DR. HESS: One point five five.

MR. LEE VAN WINKLE: And the same with the SARP.

DR. SCHMIDT: In other words, this is confirming the SARP recommendations. Other comments or questions?

If not then, all in favor of the motion, please state aye.

(Chorus of ayes.)

DR. SCHMIDT: And opposed, no.

(Motion carried.)

DR. SCHMIDT: All right. I do not believe it would be prudent to go ahead with Arizona before lunch. I

would faint someplace in between Tucson and Phoenix, and we do want to do justice to that program and the other SARP recommendations.

Dr. Thurman.

DR. THURMAN: We would not want to see you dry up in the desert, Mr. Chairman.

DR. SCHMIDT: I think that if we go now, we will be able to get back easily in one hour. So we will reconvene at --

VOICE: One o'clock.

DR. SCHMIDT: All right. There's a ground swell of enthusiasm for one o'clock. So I'll begin talking at one o'clock.

(Whereupon, at 12:15 p.m., the conference recessed for the noon hour, to reconvene at 1:00 p.m., this same day.)

P R O C E E D I N G S

1:00 p.m.

DR. SCHMIDT: We've had a couple of references to Missouri mule --

DR. THURMAN: It sounds like we're into a new joke.

DR. SCHMIDT: No. I just might say in terms of archconservatism or reactionarism, Arizona really doesn't take a back seat to very many places.

I'm reporting as a result of review of the application as well as the site visit. I was privileged to have a very strong team on a site visit that followed very closely on the heels of another site visit a year before that very clearly outlined some concerns.

There had been management assessment visit and other types of visits. This has been a well visited region.

We had Bland Cannon from the council and he was very strong and very good. He's got a good nose on him and we really got to the root of a bunch of problems.

Dr. James from the committee here was on the team as was Bob Murphy, the new director of the Tri-State Regional Medical Program, following Naomi Baumgartner.

There was very good staff support: Dick Russell and Peggy Noble and Rebecca Sadin, Mr. Morales and the Regional Health Director from San Francisco.

The site visit report is before you and it is a remarkably concise document. I could never have written it myself. It would be two or three times as long and not nearly as good.

The words are in the site visit report and what I will hope to do is give you the music that goes along with the words, and I'll tell you right now, I'm in trouble and I ordinarily like to kind of keep the suspense for the last. But the reason I'm in trouble is that I'm going to have trouble justifying the funding level that we recommended by the music that I'm going to play for you.

The point I would like to make right now at the beginning before I say anything else is that the region has done some very, very elegant and very, very good things and nothing that I will say will take away from the fact that they have been out in the region. They have done good things for people that relate to their health care needs. They have done some very elegant things. A little by accident, but they've done it. And that is an important point to make.

The region, as I said, had been given a lot of advice, and I'll go now right to Dr. Luginbuhl's concern and say that they have a very strong coordinator. Dr. Melick reminds me a little bit of the coordinators who were retired Air Force generals. He knows what is right. He has the courage of his convictions. He is a very courageous individual, or else

he's got a lot of convictions. Either way you want to look at it.

He really has known all along what RMP is, what it should be doing, what it's for. He has had the answers and as he is quick to point out, about half the time he's been right, as far as Washington is concerned.

The other half of the time, he's wrong. But if he waits enough, he feels, he'll be right again with the next switch from Washington.

He resents the visits. He calls a visit from Washington being brushed by the wings of mystery. I didn't suggest that he shouldn't really feel brushed by the wings of mystery as much as being clutched by the claws of criticism, but he obviously was somewhat antagonistic to the site visitors, didn't quite understand why we were there. He admitted in times past, and again, in so many words, that he really didn't understand the criticisms, and if he didn't understand them, he didn't agree too much with the criticisms.

He is strong and I strayed away from the word "good," but now I will say he is; he is a good administrator. He is extremely skillful in working with the staff. He's kind of a hardnosed administrator who keeps his staff on a loose rein but, nevertheless, on a rein, and it's obvious that there's a curved bit at the other end of the rein, and every once in a while, he picks these up and gives them a good twitch. And all

of the staff knows he's on the other end of the rein, but yet, they feel perfectly free to pursue the agreed upon objectives that they are working toward, and there's a remarkable esprit de corps in the staff and a feeling of solidarity and so on reflected very well on the coordinator.

The staff is good, without any question at all. The staff is good at what they were doing, and they felt also that what they were doing was good and right. And the basic questions that we had really concerned whether what they were doing well was what they should be doing at this point and time.

Similarly with the Regional Advisory Group and the other elements of the program, they really felt quite confident on how they had been and what they'd been doing. The reasons for them being like they were but again the basic criticisms, with their understanding at this point and time, in what Regional Medical Programs is all about.

They know what quality is and, again, even with the RAG members we talked to, they might at an intellectual level understand the criticisms but at a gut level, they really kind of resented them and didn't quite understand what was going on.

So I began by pointing out that the program does have real strength. We feel it has a great potential. It has made substantive and very honest accomplishments, and some of

them really quite exciting. Yet, we had to say that the program has fallen quite short of what could have been done in a region that, in a way, is as simple or could have been as simple as this one medical school in a not too highly populated area.

As I mentioned, the program has been visited a number of times before. I'll go back to the August '68 site visit which is the last pertinent one. And up to that point, the region had been planning for operational status for two years, and at that time, the site visitors felt that they weren't quite ready yet and advised a third year planning.

Another site visit then in May of 1969 did recommend operational status which was given.

Very briefly, the region is the state where there are 1.7 million people there, which eight percent are Indians, 136,000 Indians, most of them as I'm sure you know are in the Navajoland Reservation which occupies about a fifth of the area of the state, if my memory serves me properly.

Additionally, there are eleven percent Mexicans, 187,000, so this is 19 percent of the state which are minority group members.

The state is 114,000 square miles. The state has been very conservative. I'm sure at this point it still is accepting federal welfare funds. They may have changed. I'm just simply blocking that point. But they're really very,

very conservative and, in some respects, even worse than Virginia.

They're quite suspicious. The medical society, in particular, is conservative and, initially, they wanted nothing to do with Regional Medical Programs. And about the time that RMP was coming along, a new medical school was coming along and the medical school was put in Tucson, and with Phoenix being the population center with the majority of the medical expertise and organization being in Phoenix, one is naturally curious as to why the medical school would be in Tucson.

And it gets down to politics, as you might imagine. And the story that we heard from good grounds was that Phoenix needed the support of Tucson in that area in order to get a water project going, and in effect, Phoenix traded the medical school to Tucson for Tucson's support of the Central Arizona Water Project.

But it leaves kind of an embarrassment, in a way, with the medical school in the center of these sorts of activities in an area that is not the population center or necessarily the center of need.

Early on, Monty DuVal was the power in Arizona, in this area. He started the medical school. As most of you know, Monty DuVal is really kind of a saintly, very charismatic figure in Arizona, and it was obvious when we were there, I was

the only one at that point that knew he was coming back exactly when, which kept running into Monty DuVal's ghost all the time, and a lot of people just said, "Well, that was the way Monty wanted it," or "That was the way Monty would have wanted it," or "That's the way Monty's going to want it," and it was kind of interesting because I spent the two days before we went out there with Monty and Monty really ran down absolutely correctly and with great insight the problems of this region. And I think that this influences, in a way, my thinking about the region because Monty is now back in Tucson, as you know. And he really does know what has to be done.

The program was initially set up then with this brand new medical school as the base, and the steering committee that Monty put together was appointed finally, in part, in desperation by the Governor as the Regional Advisory Group.

Now, Monty was interested in that point in a state health planning authority, and in conversations with the Governor, this concept was bought and the state health planning authority was established.

The steering committee which became the Regional Advisory Group of RMP had, I think, then 16 people or 12 people, some small number, and was combined with another group that was largely consumer which served as the CHP A Board, and the RMP/RAG and the CHP Board were then put together with a

specified number of people, and, of course, the CHP specified composition of consumer/provider as the state health planning authority.

Now, one of the consistent criticisms of the Arizona Regional Medical Program is that they've got a lousy RAG. And, consistently, this has been defended by Arizona Regional Medical Program as a size and a composition that is dictated or mandated by the state health planning authority, which can only be so big, which represents then the size the RAG can be, and the Arizona Regional Medical Program knows that RMP is the provider arm and that the RAG is, to the state health authority, you see, the provider input and, you know, "let CHP be consumer that is not really part of Regional Medical Programs or the RAG."

So the RAG is small and it's very skewed toward provider and toward the position, and until very recently, with no minority representation because, in essence, there aren't minority type providers.

Now, they could have gotten around this and a number of things have been suggested such as "get a decent RAG and you can elect people out of the RAG to the state health authority," but Monty either didn't wouldn't, never will, not want this and, you know, you got tied up very quickly by reasons given for not doing this sort of a thing.

Monty appointed Melick as coordinator and he was

a good choice with Monty there. With Monty gone, he might not have been such a good choice because he kind of stayed with the initial concept and never budged a millimeter from Day One and the concepts that came along. And it's going to be fascinating to me to see what Monty does because he made that bed and he's gone home and climbed in it and how he's going to lie there, I don't know. He won't be able to, and he's got to say, "well, we're going to do something," and then do it and I know that he will.

Now, I'm ignoring my notes but I think I'm doing all right so I'll keep going.

The RMP also thinks that nobody else is any damned good, so that they know that they had to get a data base. And in the early days, continuing education was good. So about the first day, they said "our thrust is collecting a data base and continuing education."

And a year later, and a year later, and successively, the site visit teams went out and tried to convey that this really wasn't so hot anymore. The site visit team said, last year, "well, that really isn't too good," but an opening shot of Dr. Melick is that Regional Medical Programs' thrust is a data base collection and continuing education.

So that they have continued with the very large and ambitious data collecting activities, in part, because they know it's necessary and, in part, because CHP was not able

to do it and wasn't doing it and they have never forged a decent relationship with the CHP A Agency in Arizona.

Now, they do have letters from CHP A, saying that they support these data collection activities and they would be very useful to CHP in the future. But Bland Cannon smelled something here and he got the CHP A Director aside in a meeting and kind of zeroed in on that and it turns out that CHP really has no intent of picking it up, which RMP has said, and doesn't like the data and really doesn't intend to use these data that RMP has picked up.

And this was kind of a disaster, as far as the site visit team was concerned. They were cautioned a year ago that they must develop a relationship with CHP A, and the ironic thing is that Monty set this up so that there would indeed be a kind of hand in glove relationship with CHP, RMP, but all there has really been is RMP and they just don't work together at all.

Now, it's very easy if you're visiting Dr. Melick, to fault Dr. Melick. If we made a site visit to CHP, we'd probably be faulting CHP and it takes two to make an argument and two to make an agreement, and as I read the thing, I'd have to assess the thing about equally between RMP and CHP.

But the previous site visit teams did caution about this heavy data gathering activity and pointed out that it was kind of a smooth wheel and it should be a gear wheel

with cogs on it that would kind of hook into another wheel with cogs on it that would start grinding out the objectives of the program, and that gear wheel with cogs on it would be grinding out projects and they've got these wheels, but they're all very smooth and they're all spinning. But they really don't have the relationship to each other that's kind of a drive chain effect of producing what is obviously being generated as needs by the data collecting activity.

This has been said about a number of regions and during this two-day period.

The good, strong director and the good, strong core have set about doing some of the things that they were instructed to. One is to come up with a new set of goals, to come up with a plan, to come up with a review system, to come up with the sorts of sine qua nons of the Regional Medical Program.

They spent a year developing a planning notebook that outlines a gorgeous progression of project generation, evaluation and approval. It took them overly long to do this. It is gorgeous, but they haven't used it.

They worked very hard and they've developed goals and subgoals and sub-subgoals and I think sub-sub-subgoals, and the staff understands these and they are really very elegant. I don't mean to put them down.

I'm 99 percent sure Melick understands them. I'm

100 percent sure the staff does, but the few minority people that came in, some, we asked for, obviously don't know a sub-sub-subgoal from a goal, and they're confused, and they don't understand either the process that was used which was inhouse based, in part, I suppose, on the data base. But the RMP has not developed the understanding of what it's doing, the understanding of why it's doing it. They have not developed a constituency in very large and important areas.

In a way, it was almost as if they were getting ready to come in for operational status. I had that feeling that, you know, they're recycling and if they really did implement the goals and the process and all of these things they've got, it would be one of the most elegant regions there is.

They have begun to -- another criticism was in continuing education. A little bit here, a little bit here, a little bit here. You know, put it together, get a program, put it out in the state, and they have indeed started to do this in a very sound and very good way. And perhaps one of the best thing they're doing, and what they call CESA, their continuing education service areas in which they are putting people out all through the region, generating educational needs and doing this in a very sound way. It's sort of decentralization, away from the medical school of continuing education in a very good and sound way.

They have six of these areas set up. They have very definite and good plans to go ahead with this regionalization or subregionalization of education.

They say they're going to phase out the data collection. They've been told explicitely to get out of the data collecting business. They've been told explicitely to phase this into CHP A. They've been told explicitely that theirs is not to generate a state plan. That's the job of CHP A.

What they should do is catalyze and push and force CHP A to take over the data collecting, to take over the generation of a statewide plan. But that's hard to do if you aren't talking to CHP A, and they really haven't been talking to CHP A.

They did say they would be getting out of the data collecting business, and that CHP A would be taking it over, but I've already indicated that CHP didn't know about that and didn't really agree.

At this point, they really have no sound plans to increase the size of the Regional Advisory Group although they are beginning to change the composition a little bit to include some of the minority representation that's needed.

Well, just to move into the site visit report which I hope you have scanned, and to make one or two more points based on the report, in the introduction, the three

main things now I think I've kind of flushed out, were to coordinate the continuing education things which indeed they are doing, and in this, we give them an A-plus for strong support.

I really talked about the organizational structure, data collecting and the CHP business. I've covered pretty well the goals, objectives and priorities.

They haven't gotten to the point of setting priorities yet. They have this complex and elegant set of goals and subgoals which we would call objectives, and they do have a retreat scheduled with the Regional Advisory Group and there is understanding on the part of the RAG of the need for setting priorities and organizing this and getting on with it and they do plan to do this, but they haven't done it yet, which, again, is kind of this feel that they're approaching a better operational status.

I mentioned several of their accomplishments. They have done some other things and the accomplishments listed on pages two and three of the site visit report are not inclusive. They're just meant to be things that we put in the report as examples of their solid accomplishment. Their echo is the part of the data collecting activities. But they've been in the community health business. They have really helped other areas to get things going or helped other organizations to get things going, to get money. They have done some very much needed

things in the Indian land.

They have done one of the most elegant evaluations of the nurse education project in a hospital I've ever seen in which they set up criteria of nurse behavior that would be influenced by an educational program which was specifically directed at nurses' behavior, and this was a beautiful piece of work that is really quite publishable.

In general, the activities though, as you might have guessed from what I've said, have been more or less on the opportunistic side. I intimated this by saying that some of it probably was accidental in terms of taking advantage of existing situations.

They're spotty. In funny ways, they're really very mature and advanced. They do not accept, for example, projects that don't have built-in plans for other support and we really were relatively unconcerned about the business of decremental funding of projects because they seemed very well aware of this and have no intent to be in the long-term funding business.

The bottom of page four mentions Dr. Goodwin as the director of the CHP A Agency who stated, finally, to Bland that he kind of worked out of them, that Dr. Goodwin considered that the joint meetings were and would continue to be unproductive.

And part of my recommendation is that somebody

visit with Monty, and I think Monty knows but it should be stated explicitely that somebody's got to knock some heads together there, and two of the heads are Melick and Goodwin, and the only question is how hard those heads are, and how hard you have to knock them, but there's some headknocking that must be done.

It's interesting. You know, you can be concerned about racial discrimination in the south, but having grown up out west, not knowing really about the situation in the south until my adulthood, I really say that I believe that the racial discrimination in the west toward the Indian is much more serious than in the south toward the black. I really can almost sit there and cry at even lack of recognition of the Indian and --

VOICE: They're human beings.

DR. SCHMIDT: -- part of the oldtimers there as being even part of the human race, and this is really a very bad problem and it's a real problem. And so you only push but you don't push hard enough on this particular one to break anything.

I am suffering now from having to kind of talk without my notes initially.

In each section of the site visit report, as you can it, you'll see a very explicit recommendation made by the team in each subsection of the site visit report.

The recommendations really of the site visit team follow very closely the recommendations that were given to them a year ago, and I really have indicated what the recommendations are already in my remarks.

Evaluation, I've mentioned, as being quite good and, interestingly enough, we had no big problems in this area.

The needs are to do these several things: decide what the difference is between RMP and CHP and get on with it and I think that Monty has to pick this one up and go with it.

The RMP must phase out these data collecting activities and put their core staff and their money into getting out of Tucson and furthering the regionalization, the subregionalization of this RMP.

They have a very small office in Phoenix, which is totally inadequate. They do have people paid by RMP and active in the continuing education subregions, but they need very much to work with the B agencies that are there and to get the activities out.

They need to follow through on a very elegant start and get their priorities and link up now their objectives and their project generating and acitivity generating mechanisms so that they will have a program that will relate to the needs that they can now document.

When I went there, I really wasn't sure about the

coordinator and I thought maybe this would be, I think, the third or fourth region in a row in which the coordinator seemed to be the key to the problem and maybe should go. And, personally, I'm not willing to state that at all.

I think that Dr. Melick, along with somebody else, could be very superb.

The grantee organization is the university and there are absolutely no problems there whatsoever. It's a good and strong supporter as a grantee organization should be.

Well, we knew that Monty was coming back. We knew that they had done good things. We were absolutely sure that they had been hit on the head with a two-by-four several times and, really, we came down to the moment of truth, I suppose, and that is whether you had to get their attention in a way that hadn't been tried yet, which really ultimately gets down to the dollar or not, and I do want a little bit of suspense here so I'll turn the microphone over to Dr. James and let her fill in.

DR. JAMES: Sir, there's very little that I can add to the description that you have just heard and the site report that's in the book also. It's quite conclusive.

However, I have a feeling that -- and, incidentally, this was my first site visit, too, so with me, you can under-satnd my struggling in going into a very sophisticated-type program as we saw there. But I have a feeling that as we

glanced through the Arizona Regional Medical Program planning notebook which, just by this alone -- and also I'll wave a few more flags here -- in looking at their programs in terms of the structure of the planning and this is where when we're talking about goals, it comes down to goals and subgoals and then sub-subgoals and on a couple of others over here, it's sub-sub-sub-sub-subgoals. So that in trying to understand, I thought that I might have been at a full dress formal ball with the lady in plumes in the Gay Nineties and as she was dressed and no place to go, because I was, I think, first of all, struck with the excellent in-depth planning that this group certainly has utilized.

But then as we looked at this, we wanted to know what does it relate to? And after looking back at the previous site visit, and they had said the same thing, and then we're presented with I think three times more maybe than what they had presented before, it gave one a feeling of just being lost in a maze, in the forest without being able to see the trees.

It appeared to me that the excellence in the direction that the -- I want to say coordinator, and I don't mean Dr. Melick, I mean Dr. Ivey, his title --

DR. SCHMIDT: Deputy Coordinator.

DR. JAMES: The coordinator.

DR. SCHMIDT: Deputy Coordinator.

DR. JAMES: -- Deputy Coordinator had, in terms of -- the influence that he had in terms of the direction that he was able to give to the staff who are all specialists in their own rights, should be the envy of every RMP throughout the country.

I would think that many of the programs that we have discussed here yesterday and today, if they had the availability of the expertise of the planning strategy and ability that the Arizona RMP has, that none of them would be in trouble because they would have a way to know what their programs were by the data collection and understanding what the needs are and also be able to translate their programs into something that is meaningful to the people.

But, here, we have just the opposite of page after page of documented information, and I might say that we don't have with us today, but there must have been four or five books of this magnitude that were full of data collection which, of course, have not really found their way into any meaningful program.

I think one of the other things, too, that I felt keenly about, related to the minority concern and I don't think that I could express what really happened at that meeting the first day that we were there. I could not express it any differently than what you have already heard in regard to the tremendous conservative attitude toward the American Indian and

it was indeed embarrassing. I think it was embarrassing to me.

I'm not going to go into any specificity but it really lets us know how conservative the State of Arizona apparently is to the Native American who is on the soil.

We also looked at the blacks and I was very keenly aware of the fact that the lady's name that is written in the first site visit, Mrs. Tommie Thomas, was their choice for a RAG consultant -- or, rather, not RAG consultant, but a RAG member who is a member of the Community Action Commission and who would indeed, I would assure you, have tremendous problems with understanding anybody's terminology.

And then we recognized that there was a young woman that they had brought in to serve as a junior intern in the area of professional relations who was there, as we could see, as window dressing. And I spoke to her, and in the fifteen minutes, we had a list of professional blacks in Phoenix who are on the staff of the University of Arizona, who are well-known to the Dean of the medical school, who are called upon at his will to perform in certain services. And in fifteen minutes, we were able to say, "well, here are people who are knowledgeable, who are professionals, who are in health-related fields, who could lend support to a RAG program."

So we recognized immediately that the reason that they didn't have anybody there in a minority representation

from the black population "that they couldn't find," was not at all true because they were right there under their noses.

I would think that perhaps that -- I've lost the paper here. If I could find it among all the maze -- this is like the Arizona program, maze of materials.

I think that what we really saw was a performance personified, a process which has been termed "management by objectives by the deputy coordinator" which does indeed show that there is tremendous amount of conceptualization with an over-emphasis on Comprehensive Health Planning, and I can see why, at the beginning, there may have been this thrust and that was before the Comprehensive Health Planning agencies came into being, but now that the Comprehensive Health Planning agencies are there, there is somewhat, as already been stated, a reluctance on their part to give up this area of Comprehensive Health Planning.

And just to reiterate this point, someone stated that perhaps within a very short time that the data collection and the goals and the subgoals and the sub-subgoals and the sub-sub-sub-subgoals will have reached a critical mass within a very short period of time unless something were done to allow this -- it would, really literally, explode unless it were allowed to be disseminated and to become implemented.

So this is what we have seen. There's very, very little implementation, very little of a relationship to the

social welfare problems of the State of Arizona, very little relationship to interrelated health agencies whose projects would relate therefore to the people in the community.

We see a staff which is highly trained, highly educated all known as staff -- I would say they're staff specialist oriented.

The planning looks like it almost became an obsession. The planning process has become, as I see it, like an obsession to the Regional Medical Program and unless there is some way that there could be an interest to help the RMP to change its focus and to become a facilitater and a catalyst for the planning and planning/development and implementation of the program into the communities, then I think that the continued data collection will only simply lead to more data collection.

They have established a tremendous base. They have established a tremendous data base for both needs and resources, and I think that what they're struggling with is to find a way as to how they can relate to the community in order to be able to put in and implement, rather, sub-sub-subgoals.

DR. SCHMIDT: All right. Before I relinquish the chair to John for discussion, which I will, Rebecca, do you have any comments at all to add?

MS. SADIN: No.

DR. SCHMIDT: Peggy?

MS. NOBLE: No.

DR. SCHMIDT: All right. At this point, I will step out of the chair which I ordinarily would do before I began, but I didn't, so, John, you're in the chair.

DR. KRALEWSKI: Could we get a motion. Would you like to make recommendations on it then and a motion for funding and we could go from there perhaps.

DR. SCHMIDT: They are now at an annualized level of one point three eight six two six oh. Of this, about seven oh one five oh nine supports what we thought, and I would repeat, it is an excellent core staff type of activity.

They have 95,000 in developmental component now and in "other," they have about 600,000 which makes up this one point three.

Their 04 request was for seven sixty-one. They wanted to add some staff to round it out.

We felt that, really, they should add more staff than they wanted to in order to get out and subregionalize and do what they really said they would do and wanted to do in one area of their program.

Some of the increased staff would be down here in their 2,000,000 that they requested, which would be to allow them to expand the CESA, the Community Education networks throughout the region instead of just the six. They have dates for establishing eight or ten more of these.

Their request was for two point nine.

We really spent quite a bit of time in generating a level in the team and we were, in a way, quite detailed about it. We got down to a sealed balloting. And what we really agreed upon was 700,000 for core. We want them to maintain the core and, in point of fact, to be able to expand the core which they could do by getting the hell out of this data collecting business.

We wanted them to have a developmental component and the funds, flexible funds to do the right sorts of things with it, and we finally settled on 810,000, looking at their projects, looking at the sorts of activities that this could fund and, of course, the difference between -- we were impressed. When you're in Arizona, you're impressed with the drop from 2,000,000 down to 810,000 and it's a little harder to be impressed with that drop here than it was down there.

We came up with one point six which we would say would be a level of funding that would be great. It wouldn't strap them, providing they freed up other money and they could really do what I think really, with Monty there, they will do which is to get their heads knocked together, settle out very quickly the differences between CHP and RMP and we wanted them to have the money to make this program as it could be.

So that on behalf of the team, I would move approval

at a level of one point six for the next two years which is what they're requesting with the strong recommendation that Harold Margulies and perhaps Bland Cannon -- "Bland Canyon", how about that, "The Grand Canyon" -- and Bland Cannon talk to Monty and kind of explore with him the feelings of what I know will be the council's feelings as to what must be done.

So one point six with strong advice and --

DR. JAMES: I second the motion.

DR. KRALEWSKI: Second?

DR. JAMES: Second.

DR. KRALEWSKI: Discussion?

MRS. FLOOD: I must express concern for the approximate 20 percent of the population that is of Mexican American origin in the State of Arizona. Distress has been expressed for the black and for the Indian population, and 20 percent of the population in the state is Spanish speaking and, yet, I can find hardly any projects that have as their prime -- well, I can't find one project that has as its prime emphasis addressing the problem of the health delivery systems to serve this minority group.

There is a project that serves it as a secondary influence only, and if you thought the black employee was window dressing, I don't doubt that the Mexican American is window dressing, and I would probably assume that he is stationed in that small cubbyhole in Phoenix, away from the

main core staff. That's so they won't have to see him too often.

I feel a tremendous consternation that we insist that the coordinator is a good coordinator; that he is strong, there is no doubt in my mind, but a good coordinator.

You know, we bandy that term around this table. We say, "He's a good coordinator." But this is happening in the program. That is happening in the approach.

There's no doubt that this coordinator is strong, that curved bit and those reins I think also have a crop hiding somewhere behind, and if anybody tries to mesh those wheels to a productive, interproductive mechanism, I think the crop comes out of the riding boot and (cluck) flips them, too. At least that's the feeling I get.

And I feel strongly that the advice letter that goes forth should no longer allow this to continue for another year or more.

DR. SCHMIDT: Point of --

DR. KRALEWSKI: Would you like to comment?

DR. SCHMIDT: Just point of clarification.

There are eight percent Indians, eleven percent Mexican and Spanish American. The combination gets close to 20 percent but it's eleven percent Mexican Americans, I think.

MRS. FLOOD: But there's 19 percent, I believe.

DR. SCHMIDT: Pardon?

MRS. FLOOD: I believe it's 19 percent Spanish surnamed. At least the briefing document listed it as 19 percent estimated at -- the Spanish speaking is --

DR. SCHMIDT: Okay. There is a problem here. I think that the Spanish surnamed individuals are accepted into the culture, you know, just way above the Indian who really isn't considered much of anything and, of course, some of the aristocracy is Spanish surnamed. For purposes of RMP, they are not counted as a minority group.

The eleven percent I'm referring to is not -- this is complicated, and it was explained but they didn't --

MRS. FLOOD: The purposes of Arizona's RMPs, they're not counted as minorities.

DR. SCHMIDT: Well, they really aren't in Arizona. Some of the aristocracy in Arizona is Spanish surnamed and they are not counted in -- the eleven percent includes, in essence, Mexicans; does not include all Spanish surnamed. So I'm saying that you may be correct if you count racial extraction. It would be higher than my eleven percent, which is Mexican American.

DR. KRALEWSKI: I think if you consider the underserved population in Arizona, you'd have to conclude that the Chicano population makes up a good part of that.

But as I recall from the visit a year ago, a number of their programs that they had developed, not specifically

developed by RMP but developed as a result of the data provided by RMP and the RMP staff effort, those programs were oriented toward the underserved areas including the Chicanoes.

I would hope that those programs had proceeded over the years.

DR. SCHMIDT: Yes, certainly the identification of streptococcal, that project is really very much in the core areas in this project that is an example of something that is directed right at need and, of course, the rheumatic fever statistics in this area bear this out.

There are indeed activities that do involve -- it's one of the first things I said -- that do involve care to Indians and care to the Mexican Americans.

DR. JAMES: The streptococcal program relates primarily to the Indian population. I think that there was clearly elucidated one of the severe problems that the Mexican Americans were involved, and that is not being on various boards to help at the decision-making level and they, through their own efforts, have received a federal grant to help train the Mexican American in developing themselves into individuals who could serve as policy-making people. And, this, they had attempted to do, as far as I was led to understand, through the RMP. But because such help was not forthcoming, they sought outside help and I think that many of the councils, the Southwest Council of La Raza -- is that correct? --

and many other of the Spanish speaking councils were tremendously involved in this so that they are able now, through a federal grant, to have a formal program which will help to train the Spanish Americans in this role.

We certainly also were aware of the fact that the community health service in Phoenix, I believe, came from the help that the Regional Medical Program was able to offer.

But there is no such program elsewhere in the state that I could discern or as I remember that this is the beginning of a kind of program as it relates.

We were talking about the CESA program. It was noted that the CESA program was certainly very high up in the community; that is, not related directly to the people but more or less professionally oriented to the nurses in the hospitals and it wasn't yet clear in terms of their household survey as to how they were really going to translate their continuing education program into meaningful health delivery services.

At least it wasn't clear to me. It may be more clear if I perhaps read it a little bit better, but there was just -- they got so far, it seems, and they got hung up and they couldn't spread the program to involve the majority of the people, and I think a lot that has to do with that is geography.

DR. KRALEWSKI: Thank you. Miss Kerr.

MISS KERR: Of consternation to me, if it is true, why hasn't there been a site visit prior to that. That is, it seems to me that this is the second and this the first that I've been hearing on it.

We've had the same concern about the data collection, the reluctance to give it over, I'll put it that way, to CHP, all these promises, CESA was going in and I don't think it's broadened it out too much more since then, since I've seen this.

I think the stem-winder of the staff is Mr. Ivey and not Dr. Melick.

I agree with you. I think he behaved like a general. But I think that Dr. Melick -- and I also feel as Dr. James, that I think they're making too much of this planning, the sub-sub-subgoals were established before we were out there.

I don't see that they clarified them or started working with them and make them meaningful or that people can even understand what they've done with them.

And I would make two comments. One, I hope we don't, as a review committee, tend to sanctify Monty, too. I don't know who Monty is. I've never met the man. But I hope we don't tend to sanctify him. I don't know in what position he'll be brought in when he returns. Can somebody tell me this?

DR. SCHMIDT: He, Monty, is going back as the vice president for health affairs.

MISS KERR: At the university?

DR. SCHMIDT: At the university.

MISS KERR: Well, are they going to have all these strings to pull on the Regional Medical Program and the grantee institution?

DR. SCHMIDT: When Monty goes back, Monty is going to be the one single, overpowering, powerful voice in health affairs in the State of Arizona.

The medical school has never usurped or co-opted any Regional Medical Program in the typical sense.

MISS KERR: No. I know it hasn't.

DR. SCHMIDT: But what happens with CHP, RMP and son, Monty is going to say, and that's just a fact.

MISS KERR: Then my other statement is as I read through the site visit, the recommendations, I saw many "ifs," if such and such happens and if such and such happens. And I don't think we're sure what's going to happen, and what little change I've seen between the two site visits, I'm not too encouraged.

So I frankly think that your funding recommendation is generous.

DR. KRALEWSKI: Yes, sir.

MR. TOOMEY: I would ask Dr. Schmidt. Your

recommended level of funding is $220,000 approximately above the 03 year, the current year, and you do talk about the potential for reduction in their program staff expenses if they do get out of this data gathering.

It would seem to me that when you look for a lever to get them to do something that you want done, you know as you said yourself, you look at the money, and it would seem to me reasonable to reduce that from the one million six. Leave it at a leval funding of what it was a year ago and encourage them in terms of their growth, encourage them this way to leave the data gathering elsewhere.

And if it's feasible, Mr. Chairman, acting Chairman, I'd like to so recommend.

DR. KRALEWSKI: I will take that as a recommendation but not just as a substitute motion at the moment if that's agreeable with you. We would like to have a little more discussion. Thank you.

DR. THURMAN: I guess I voice the same degree of concern. I share Mrs. Flood's concern because anyway you want to get around the Spanish surnamed business, it's still putting them down.

I think the second thing would be that I don't see that there's any degree of reaction about Dr. Margulies' letter of December the 10th of 1971 in that he says there what we're saying here, which is really what Elizabeth is saying.

My questions I think to the site visit team would be: who is going to knock the heads? And if that's going to be Monty, who's going to tell Monty? And how long is Monty going to be vice president?

Those are the three very critical questions. They are asking in that data business, when you get right down to it, they asking for an 04 and an 05 year. The 04 year is well over $500,000, and I think that the most damning thing that I saw, although somebody recommended it be included, was the speech that he delivered on November the 14th, 1972, "awaiting your arrival," in which he said, "we're going to be more independent," not less dependent and that they're going to let us do what we want to do and that we plan to carry on the collection network.

He specifically speaks to 1974 and 1975, with no feeling about them being funded from any place else. So that I think we're being much, much more than generous with the one point six.

I agree that Dr. DuVal is certainly the power in the state and I think that to pull it off well, there's no reason why they couldn't come back in a year of performance. But a year of no performance, to me, doesn't justify an additional $300,000.

DR. KRALEWSKI: I think the discussion then has centered then on really three issues. One is the minority

problem on whether this program is responding to the needs of the underserved and minority groups in that region. Number two, whether the site visit team really believes that the program will take a turn in kinds of activities they are involved in, whether they'll make some changes this coming year that they perhaps have not made last year, whether the progress last year justifies this trust. And then, number three, whether we need to use funding or some kind of conversations with Dr. DuVal or whatever to try to bring that about.

I wonder if I can get the staff at this point to make some comments on those issues or any one you might want to raise. Mr. Russell, do you have any comments?

MR. RICHARD L. RUSSELL: I'd like to, but I would like to go off the record if I might.

DR. SCHMIDT: All right.

(Discussion off the record.)

DR. KRALEWSKI: Do you have any comments you would like to make?

MS. SADIN: The only thing I want to say is I don't know whether they had those new projects last year, the ones that they're going to move out. They do have some new ones, one point five or something, streptococcal, one point four or something, and I don't know that they do have a new program.

MISS KERR: Since Mr. Russell has spoken so frankly, I feel that --

DR. SCHMIDT: Hold it a second. Are we on the record or off the record?

DR. KRALEWSKI: I think we should go back on the record.

DR. SCHMIDT: Back on the record.

MISS KERR: I sense a feeling of defiance. I didn't say it before, but in a sense, I do in comments from the staff. They've known and, yet, they don't seem to listen.

DR. KRALEWSKI: Do you have any response to that, Dr. Schmidt?

DR. SCHMIDT: Yes, I do. This is admittedly difficult. I began my remarks by saying that I kind of figured I'd be in trouble. I knew why, and I think I was right. But I don't like to punish a region.

And the last remark, I think, conjures up some type of a retributive "We'll teach them to pay attention to us" type of act and I really would caution very much against this sort of thing.

Our goal in evaluating the program, and believe me, when we left, everybody was kind of shaking. We weren't exactly escorted out of town by the state guard but we were not easy on them. Some of the feedback I've gotten since is that they maybe for the first time did begin to get the message.

That may not be true.

But our goal is to build a good program.

Now, the coordinator is strong and he is good in many respects. The word "good" is obviously judgmental and, you say, what are the criteria? And in some respects, he's bad and strong. I think he has been leading them sometimes in wrong directions and sometimes he's not been leading them in a direction that we would consider good.

So I would re-emphasize some of the activities in the CESA and some of the others, he is leading them and permitting Ivey to lead and so on, in very good direction, and some of the things they have done are good.

They are planning the management by objectives. These are good things. These are not bad things. These charts are superb. They are elegant, they are eloquent and they are needed and they are good.

The question is, will they take the next step? And part of our recommendation is that they be instructed, they be ordered to get out of the data collection business in one year, within one year, and there will be zero funding for that after this year.

We recommend that they be instructed that there must be a statewide plan and that is not their job, that will help guide the generation of the project, that they be instructed to follow up on these things.

Now, I am frankly biased. I am biased by the conversation I had with Dr. DuVal before I went out in which I ate dinner with him the night before I went out. That afternoon, I'd been in the Secretary's office when the call came from Camp David announcing Weinberger's appointment, and Monty turned to me and he said, "Well, I'm going to be home by Christmas."

And we went out, and everybody fled from HEW to the nearest friendly bar and Monty and I went out and had dinner and he wanted to talk about Arizona, and he reviewed the history of the program and he told me exactly what we would find, and, indeed, we did find that. You heard it today. And Monty knows this.

He also knows what must be done. It is not more than 50 percent the fault of RMP that there is not a state plan or that they don't have relationship with CHP. It's not more than 70 percent their fault on some of the other things.

To me, the issue is whether they can build a good program and their projects would give evidence that they can. Their core staff is excellent. Their planning is excellent. The strength of their leadership is there, and really, it comes down to our not wanting to deprive them of the funds that it will take to move ahead in the right direction and we are banking, whether the team banking or my

own banking, on what the instructions are from here as to what they may not do anymore, period. Not suggested but to tell them.

And I said that at least Bland Cannon and Harold Margulies should talk with Monty DuVal and we should mount a return visit, in other words, out there to lay down the law. Now, this has been done before and it's been done quite effectively.

So that the reason for the one point six, and I will say that I am not -- I wouldn't stick my arm out under a knife at one point six. I would begin to dig in my heels quite strongly much below the current funding level because my betting is that Monty, et al, will build a good program and that is what we're about.

DR. KRALEWSKI: Response to that or new issues? Yes.

DR. BRINDLEY: Could I ask just a question of "our former chairman." What would you think about have it reviewed at the end of one year rather than approving two years' funding with the thought that if they do a real good job as we all hope they will, actually one point six may not be enough to do the things they could do, if they do not respond to your suggestions and recommendations and do not make any change in their thrust, one point six is probably too much.

DR. SCHMIDT: Well, I wouldn't -- you know, in effect

given the last two days' discussion, I'd put them on probation at the consisten funding level and, you know, tell them.

DR. BRINDLEY: But reviewed in one year.

DR. KRALEWSKI: All right. Let's go on to further discussion and we'll come back.

DR. LUGINBUHL: Where do we stand in terms of the motion on the floor?

DR. KRALEWSKI: We have a motion on the floor and seconded.

DR. LUGINBUHL: Are you doing any point of amendments?

DR. KRALEWSKI: Yes.

DR. LUGINBUHL: I'll move to amend the motion to level funding and review in one year.

MISS KERR: I would second the motion.

DR. KRALEWSKI: Okay. It's been moved and seconded that we fund them at level funding and review them, site visit --

DR. LUBINGUHL: Yes.

DR. KRALEWSKI: -- at the end of one year and then decide for future funding. Any discussion on that?

DR. JAMES: Yes. And relative to the advice, we've put tremendous amount of concern in terms of getting out of the data collection business, I would like this committee to make a strong recommendation to advise them that they must pull

in quality/qualified representation from the three minority groups that are highly representative in that state, including the American Indian whom epitaphs were spread out about the table, including adequate American Indian representation, includir adequate qualified Mexican American representation and, certainly, from the minority black group in the state.

I would highly recommend that this committee also include that as a specific in the recommendations; advice, rather.

DR. KRALEWSKI: Dr. Schmidt, was that inherent in the advice that you had in mind in your original motion?

DR. SCHMIDT: Yes. I think that the site visit report, one by one, ticks off really all of the advice that we would give.

DR. KRALEWSKI: Is there further discussion? If not, then we will vote on the amendment to the original motion and that amendment is that we fund them at level funding for one year, site visit at the end of that time.

Is that clear?

All those in favor, signify by saying aye.

(Chorus of ayes.)

DR. KRALEWSKI: Opposed? Carried.

(Motion carried.)

DR. KRALEWSKI: We now need to vote on the original motion since that was an amendment to it. Everyone in favor

then of passing this as the motion. It will be level funding until the one year, as mentioned. Please signify by saying aye.

(Chorus of ayes.)

DR. KRALEWSKI: Opposed? So carried.

(Motion carried.)

DR. SCHMIDT: All right. Thank you.

One housekeeping bit before we move on to the next agenda item and that is if you want your book, leave a piece of paper here saying you want it sent. If you don't, say "please don't send it." So here's a --

VOICE: Just a technicality. What do you do with the third year as far as showing our support for the program --

DR. SCHMIDT: I would interpret this as a review committee as unwilling to make any commitment for the third year at this point. They are, in effect, on probation and, you know, they're zeroed out unless they shape up.

Monty ought to be able to explain that to them all right.

DR. THURMAN: Would RMPS pay for the armor for the site team?

DR. SCHMIDT: I don't know about that, but I'm glad I'm a few miles away. I now can't go into Florida, Indiana, Arizona, Virginia and some others.

All right. Well, I think this discussion, like so

many others, demonstrates the wisdom of a review committee and the peer review process.

We have one last piece of business which really is more informational than anything else. It's the report to the review committee on the actions of the staff anniversary review panels and these recommendations will be recorded by committee members.

So let me first call then on Mrs. Flood.

MRS. FLOOD: For Alabama.

DR. SCHMIDT: For Alabama. You have only the one or --

MRS. FLOOD: No. I have Alabama, Illinois and Northlands.

DR. SCHMIDT: Okay. Well, just take them in order.

MRS. FLOOD: All right. We will begin with Alabama. There is an item of interest in the SARP report regarding the -- I will quote from the report -- the dropping of Dr. Hill as Alabama RMPs paper coordinator which was felt to be a positive step in the development of this regional program.

The program has some deficits in minority interests but is recognized as a leading group in the development of answering the problems of health care in that state.

They were requesting for their third year, operational year in the triennium -- it's their fifty operational year -- $875,908 for program staff. The SARP recommends that

that be the approved level.

Contracts allowed at $10,000, the same requested level.

They are recommending a developmental component. They have markedly decreased the amount in the region's request for operational projects from 2,141,224 to 779,649 which then totals to the amount approved by council for the third year of their triennium of 1,765 dollars -- 65 thousand five hundred and fifty-seven dollars, which is quite a drop from the region's request for the third year of its triennium.

I have no other comments regarding Alabama on this.

DR. SCHMIDT: We'll just say if any committee member has a question, if you will break, otherwise just go right on ahead.

MRS. FLOOD: The next region that the SARP reviewed was Illinois which was, again, rated as an excellent program.

Their requested funding level of $2,000,800 for the second year in the triennium, and is also council approved level, and the SARP recommends approval of the funding at this level with a developmental component of $152,428.

There's one question that I would like to pose as to the Illinois Regional Medical Program. There is mention in the briefing document that in the October '72 RAG meeting, that body for the Illinois Regional Medical Program adopted unanimously a resolution defining their region of concern as the

entire state of Illinois.

I have to ask what effect this has on the bi-state REgional Medical Program in its endeavor to serve the south-eastern portion of the state.

There was some discussion of turf problems there at the September review committee at which time bi-state was reviewed and I had thought that there was some recommendation that the two coordinators and the RAG representation, also grantee institution, get together and try to define the responsibilities in these overlapping areas.

I would like to question if any other member of the committee or member of staff could offer us any insight as to what potential problems this resolution of the Illinois RAG will provide.

MR. CHAMBLISS: Mrs. Flood, I think Mrs. Houseal could answer that question. She's the operations officer for bi-state.

MS. DONA HOUSEAL: Can't remember. Staff has gotten together on this and in the near future or some time in the next couple of months, Dr. Margulies intends to begin the steps of bringing about a resolution of this which will include bringing the coordinators together. We are taking steps to do so on that.

DR. THURMAN: Does that answer the question?

MRS. FLOOD: Well, it doesn't really resolve the

problems, but I'm not sure that we are --

MR. CHAMBLISS: It may not resolve the problem because the problem is not resolved.

MS. HOUSEAL: There are no plans to abolish the bi-state out.

MR. CHAMBLISS: No, there is not.

There will be discussions with the coordinators perhaps along the lines of the Intermountain concept that you heard explained earlier. But there will be efforts to bring them together to work out this issue.

MRS. FLOOD: Point of interest, I'd like to know what the results of these conferences were, for future information.

MR. CHAMBLISS: We will report those results to this committee.

MRS. FLOOD: Thank you very much.

The third region assigned to me was Northlands. They were requesting, in the third year of their triennium application, $2,699,447.

The staff anniversary review panel made some comments regarding minority involvement in that particular RMP. There was also some concern about the development of their goals and objectives since there had been little minority or consumer input into the development of the goals and objectives, and their recommendation was for this third

year of their triennium to fund them at $1,750,000 with a developmental component not to exceed $150,000.

DR. SCHMIDT: All right.

MRS. FLOOD: Any questions that I might be able to answer?

DR. SCHMIDT: If there are no questions then, Dr. Elliss.

DR. ELLIS: All right, Mr. Chairman.

I have been assigned the office of Regional Medical Programs. The program was reviewed by the staff anniversary review panel. I can be very brief.

The request from the region was for $2,388,000 plus and the recommendation of the council-approved level for this year was one point seven hundred thousand.

The recommendation of the SARP is that the council-approved level -- They approved the council-approved level of one point seven hundred thousand in direct costs, and this recommendation includes a developmental component and maximum funding of $375,000 for kidney disease project.

The request of the region was more but it was the reasoning of SARP that although the region's track record was good, they had not given evidence of extraordinary progress during the past year or they saw no reason for increasing it above the council's level, particularly because some of the existing problems which had been pointed out had not yet been

corrected completely, but progress, great progress has been made.

The second one is the Iowa Regional Medical Program. For the fifth year, the region requested $918,000 and this was recommended also but the council level of funding was a little less.

The panel, the staff anniversary review panel recommended that the program be funded in the amount requested, and this includes $79,000 for kidney disease activities and this program has really made excellent progress and has moved beyond expectations in many of the areas that had prevented a very well-coordinated plan of '73, '74 which indicates that they are working according to plan.

And the other is the Ohio Valley program and the request -- the council-approved level for the second year is $1,639,000 and the request is two million five hundred and seventy-one million (sic.) and it is the recommendation of SARP that the region be funded at its fifty operational year, second year triennial at the council-approved level of one point six. And this includes the developmental component.

It was the feeling of the SARP that this region is strong, a strong, viable region, but I think it probably has developed some of the best relationships in working with the CHP and OEO and all of the other areas. I myself am not so sure about the involvement of the minorities and the panel points

out that this is an area, too, that needs strengthening.

The only thing the panel did do which put them a little below the recommended level is that they discussed at great length the university continuing education resources and they felt that this program had been in operation for about four years and is scheduled to continue and that it is based on activity within the three medical centers and they feel that they be advised, the region be advised to seek other means of support beyond the committee period of this support.

Do I do anything by way of making a --

DR. SCHMIDT: No. Thank you. And Miss Kerr.

MISS KERR: I'll try to be brief. Florida is in the second year triennial and I might report that you will recall that Florida had some bumpy times prior to about a year ago when the site visit team came back excited and excited us about the turnaround they had made, and they were then rated 354.

It seems that Florida continues to do well. The panel indicated it has shown dramatic program development. New priorities have been established in the areas of neonatal care, midwiferies, sickle cell disease and outreach programs utilizing indigenous personnel.

There were minor -- two minor concerns. I don't know how minor, but at least not major. It was noticed that the projects, several of the projects were supported -- were

university-based junior college affiliated or associated with state agencies and the panel felt perhaps that the region should look beyond the traditional or formal establishment grounds to support new projects.

And then there is a Project 44, Manpower Development in Education which, at this point, seems to focus on medical education and it is concerned that it should and eventually hopes it will be directed toward other health professionals.

At this point and time, the last year they were funded at two thousand two hundred and forty-eight thousand seven hundred and six (sic) and council approved that amount.

The request for this year is two thousand eight hundred and three dollars, two thousand -- no. Two million eight hundred and three four ninety-nine.

Council had approved the level of two million two forty-eight, seven oh six, and the panel has recommended that it be kept at the level of two million two hundred and forty-eight thousand seven hundred and six for the ensuing year and gave it a rating of 342 which seems to indicate a real strong approach.

DR. SCHMIDT: Before you go on and for the benefit of Drl Luginbuhl and others who have really been in a way very interested on what the effects of review committee actions and site visits and so on can really be, what kind of leverage, what kind of clout do you have, I think it's safe to

say that this region was unmitigated disaster area at one time.

There were subregions trying to secede from Florida, if you can imagine that. It was really a mess, and as a result of site visits and strongly worded concerns of review committee and so on, this region did, in fact, turn around in the face of problems with the grantee, the RAG, the staff, the whole business, and it is an example of the effects of the review committee and the site visit processes, I think.

Okay. Thank you.

MISS KERR: Now, we go to New Jersey which had a previous rating of 413. New Jersey is in its third year of triennial, and essentially, I think the same thing can be said about New Jersey.

The panel feels that it is moving along very well and carrying out its programs as intended and is effective. It did, however, recommend that more professional minorities be represented on the technical review committees and the urban health task force committees. This was the primary criticism.

In view of the success of the program and the endeavors that have mounted and its accomplishments, the panel's recommendation is to increase the funding level for this region of medical program in recognition of its continued success.

The year four was funded at the level of two thousand

one hundred. Council approved a level of two million one hundred thousand. Council approved the level of two million nine hundred and ninety thousand.

This year, the region is requesting two million nine hundred thousand. It has been approved by council and the recommendation for funding level is two million five hundred and fifteen thousand dollars.

Now, the next one I may have to ask some staff support on because it's a little knotty. I neglected to tell you that the previous rating was 413. The present rating was 403, so that would seem to indicate continued effective activities.

This is Tri-State which is Massachusetts, Rhode Island and New Hampshire. It's in its third year of triennial. Its last rating was 343. Its last site visit was in October of '70 and it's had four staff visits in the last twelve months.

There seem to be problems that the staff have observed. Principally, they are the following: in response to the 1971 advice letter, there are seven major points directed to the region. One was a need to strengthen the program activity in the primary care delivery area. And in response to that, two of the regions' new, not previously approved, projects are in the primary care delivery area, and an emerging medical system project was initiated last year.

There was concern over limited minority involvement in the Tri-State structure and on the program staff. That situation evidently continues; inadequate minority representation.

The categorical subcommittees do not appear to serve the needs of the overall program.

An increased effort toward strengthening the program evaluation was indicated possibly through the redesign of the subcommittee structure.

The problems category as identified by interviews with health leaders are being used as a framework for Tri-State's program evaluation. It appears, however, that they have no relationship to the four program elements or goals of the region.

Another concern is the program priorities established in 1970 do not relate to specific regional or subregional problems which are identified as warranting immediate attention.

There appears to be a lack of program thrust.

Concern was also expressed that was was formerly Project 17, The Regional Organization for the Care of the Cancer Patient, was initiated as a contract in amounts over the $25,000 limit and it was felt that the region may be bending its rules to accommodate special interest groups.

So there are some accomplishments, and it all

isn't backsliding. It does have a new structure committee and it's under review. Central staff positions have been reallocated to the subregional offices. Program staff continues to be recognized as a resource to those seeking to improve the health care in the region.

The budgeting reflects categorical primary care emphasis and there are an increasing number of funded projects and contracts which have demonstrated evidence of joint funding.

In recommending funding, the rationale behind it is that the region's progress was not considered satisfactory to warrant an increase of its 1971 council-approved level.

The issues that were addressed in the advice letter, especially minority involvement, the Tri-State RMP was not adequate.

Requested increases in personnel and developmental component were not justified since the region is in the process of evaluating its total program.

Now, it may be that staff will want to go in to more detail on this, but I point out the fact that there are some concerns that have made both staff and SARP take a very close look at the funding level.

In year four, present year, it's two million and a half, and this was approved by council. Council also approved two million and a half for the year five. However, the region

has submitted a request for three million four hundred and seventy-five thousand and it is SARP's recommendation, it seems reasonable to me in view of their observations, that the level for this year be at the sustaining level of two million five hundred thousand which is as it was last year.

DR. SCHMIDT: All right. Thank you.

I think we'll leave it at that. It would be proper for me to say that these recommendations must go on to council and that these are included in the confidentiality statement and these are to be considered in the same way as any other applications and actions.

I would receive a motion that these reports from SARP be accepted and endorsed by the review committee.

DR. BRINDLEY: Make such a motion.

DR. THURMAN: Second it.

DR. SCHMIDT: All right. It's moved and seconded. All in favor, please say aye.

(Chorus of ayes.)

DR. SCHMIDT: And opposed, no.

(Motion carried.)

DR. SCHMIDT: All right. With a reminder to signify whether you wish or wish not the material sent, I will once again say to a hard working and most excellent committee, thank you, and we shall meet again.

MR. CHAMBLISS: May I just say that inasmuch as

Dr. Margulies was unable to return that we do appreciate your time, your interest and your effort and on behalf of the staff, may I let you know that. Thanks.

(Whereupon, at 2:45 p.m., the conference was adjourned.)